Outlook

A Self-Directed Outlook: *Transition through Leadership*

SERVICE MODEL & PRACTICE GUIDELINES

August 2011

An Enhancing Sector Capacity Initiative Funded by the Department of Human Services

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Section 1: Service Model

Definitions

Day Service: Day Services (previously referred to as an Adult Training and Support Service (ATSS)) provide supports across a range of lifestyle areas including daily living and vocational skills, community participation and inclusion and recreation for people assessed as having a disability under the principles of the Disability Act 2006.

Self-directed Approaches: Recognise that the person with a disability is at the centre, and to the extent that they are able, should be in charge of planning, funding and support responses. Self-direction also recognises the need for complementary work to ensure that communities are welcoming and inclusive.

Day supports should be self-directed to the greatest extent possible and contribute to people pursuing a lifestyle of their choosing including:

- ⇒ supporting and/or enhancing their daily living activities and skills
- ⇒ enhancing their vocational skills and opportunities for employment
- ⇒ actively participating in a range of socially valued roles, interactions and activities in the community
- ⇒ pursuing activities relevant to their individual lifestyle aspirations
- ⇒ ensuring it is broadly typical of someone of their age and cultural background.

Self-directed Planning: Planning that is led by the person with a disability, based on their individual strengths, interests, aspirations, choices and goals.

Self-directed Supports: Flexible supports which enable participation, well-being, social connection and independence, such as disability specialist supports, and community and informal supports (i.e. family, friends).

Community (Capacity) Building: Enhancing disability supports through community engagement, partnerships, development and education; community participation and empowerment.

Community Planning: Identifying themes emerging from self-directed plans to inform planning activities regarding community activity / participation.

Personalised Supports: Supports that are developed specifically by and for the person. This means that, in line with the informal supports and funding available to them, the person can determine the activities they participate in, the time of day or week the supports are required, and whether they share the supports with anyone else.

Social Inclusion: The Australian Social Inclusion Board (ASIB) (2009) states that *"a socially inclusive society is one in which all Australians feel valued and have the opportunity to participate fully in the life of our society."* The ASIB proposes that to be socially included, people must be given the opportunity to:

- ⇒ Learn by participating in education and training
- ⇒ Work by participating in employment, in voluntary work and in family and caring
- ⇒ Engage by connecting with people and using their local community's resources
- ⇒ Have a voice so that they can influence decisions that affect them.

Enhancing Sector Capacity (ESC): Department of Human Service's funded reorientation in the delivery of Day Services from centre-based to community-based with an emphasis on self-directed approaches.

Outlook's Purpose, Vision and Values

Outlook's business focus, strategic directions and practices reflect parity with the principles and philosophies that underpin the Disability Act 2006, State Plan and Quality Framework. Much has been achieved over the past five years at all levels in shifting organisational culture and mindsets of staff, clients and carers, recognising that in order to truly embed a philosophical approach within an organisation, it must be:

- ⇒ integral to all key guiding documents – core purpose, vision, values and strategic plan
- ⇒ recognised as a shared responsibility (exists independently of any individual)
- ⇒ able to transcend changes in organisational structure and context (organic)
- ⇒ an 'invisible' part of the way the organisation functions at all levels.

Outlook reviewed its purpose, vision and values in 2010, in the context of social justice for people with disabilities, Outlook's strategic priorities, government policy directions and relevant legislation, and the resultant guiding statements and associated practices will be fundamental to successful transition to self-directed service delivery.

Outlook's focus is on meaningful social inclusion (access to and participation in local communities) through building community capacity (community education and development; linkages and partnerships) and creating positive mindsets (focussing on rights, strengths and abilities).

Mission

Inspiring inclusive communities through diversity

Vision

Outlook- Leaders in social enterprise

Vision Statement

Outlook will continue to grow as a nationally recognised leader in dynamic sustainable social enterprises; respected for its innovation, diversity and excellence in community inclusion and environmental outcomes.

Values

Values	Practices
Integrity	1. Outlooks commitment to integrity exemplifies honesty, trust, equality and respect for the individual. 2. Accountability and a Duty of Care to staff, service users, families, each other and the wider community. 3. Fostering dignity and self-esteem through respect for the rights of the individual.
People Focussed	1. Personalising by being open minded, empathising, listening, and supporting individuals. 2. Promoting empowerment and inclusion through Advocacy with individuals and on behalf of communities. 3. Working as a team player dedicated and committed to empowerment and personalised approaches. 4. Building trust with stakeholders, partners and wider community. 5. Providing opportunities for personal growth and inclusive relationships. 6. Outlook puts people first, by encouraging and supporting individuals to meet their potential
Inclusion	1. Working together to facilitate flexible opportunities for individuals to be accepted, participate and belong. 2. Partnerships with the wider community, leads to meeting the needs and expectations of people
Ethical Business	1. Entrepreneurial business that is conducted in a way (ethical manner) that includes: Quality, partnerships, training/education, communication, OH&S (staff welfare, life balance), environmental, legal compliance, efficiency, inclusiveness, outcomes and flexibility.
Diversity	1. Promote and provide choices through progressive innovation
Continuous Improvement	1. Excellence in service delivery and personalised outcomes through commitment to quality, accountability and continuous improvement.

Underlying Principles

Outlook's governance, operational management, infrastructure and service delivery systems are planned and administered based on the following principles.

- ✓ **Social Justice / Human Rights - dignity, freedom, respect, equality, access and fairness**
- ✓ **Honesty and integrity**
- ✓ **Diversity**
- ✓ **Inclusion**
- ✓ **Person-centred, strengths-based and self-directed methodologies**
- ✓ **Civic value and participation**
- ✓ **Confidentiality and privacy**
- ✓ **Ethical practice and quality service**
- ✓ **Consumer input into organisational improvement**
- ✓ **Community capacity building**

In line with the State Plan and Quality Framework, the philosophical underpinning of self-direction is concerned with *genuine* community connectedness and inclusion through:

- ⇒ Planning based on individual strengths, interests, aspirations, choices and goals
- ⇒ Flexible supports which enable participation, wellbeing, social connection and independence
- ⇒ Individual empowerment, choice and civic participation
- ⇒ Community capacity building and integrated planning.

Compliance

Outlook's proposed ESC service model, in line with Outlook's broader practices, will be restructured and operationalised in a manner that is compliant with:

- ⇒ The Disability Act 2006
- ⇒ Information Privacy Act 2000
- ⇒ Health Records Act 2001
- ⇒ Intellectually Disabled Persons' Services Act 1986 / Regulations
- ⇒ Victorian State Disability Plan 2002-2012 (Department of Human Services 2002)
- ⇒ Victorian Charter of Human Rights and Responsibilities Act 2006
- ⇒ Disability Discrimination Act 1992 (Cth)
- ⇒ Quality Framework for Disability Services
- ⇒ Growing Victoria Together (Department of Premier and Cabinet 2001)
- ⇒ A Fairer Victoria (Department of Premier and Cabinet 2005)
- ⇒ United Nations Convention on the Rights of Persons with Disabilities (United Nations 2006)
- ⇒ Disability Discrimination Act 1992
- ⇒ Equal Opportunity Act 1995
- ⇒ Racial Discrimination Act 1975

⇒ Sex Discrimination Act 1984

⇒ Occupational Health and Safety Act 2004

⇒ Accident Compensation (Workcover Insurance Act).

Service Model Description

Enhancing Sector Capacity (ESC) Objectives

The objectives of Outlook's ESC project titled *A Self-Directed Outlook: Transition through Leadership,* are as follows.

1. To build on the findings of the Changing Days project through trialling key recommendations and refining innovative strategies for transitioning to self-directed approaches in day supports.
2. To trial an alternative service delivery model that creates staffing and cost efficiencies enabling a more individualised service mix.
3. To document a service framework, practice guidelines and position description that reflects the requirements for implementing self-directed and individualised approaches across the Day Services sector.
4. To enhance the capacity of the sector to increase the number of people supported by self-directed and more personalised supports through sharing of learnings and resources.

Historical Development

The historical shift in disability service provision from care and protection to community capacity building and social inclusion is best depicted in the following diagram (DHS, 2009 *Community Building Program Practice Guide V1.4)*.

Institutional Approaches	
Starting Point	Person as Patient
Target of Change	Person with a disability
Service Settings	Segregated, Congregate care in Institutional Settings
Dominant Professional Context	Custodial, Medical Strategies
Planning Strategy	Isolation, exclusion, containment and protection
Priority	Meeting basic needs
Goal	Control or cure

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Deinstitutionalisation Model	
Starting Point	Person as client or consumer
Target of Change	Disability Service Settings
Service Settings	Community Based Specialist Services
Dominant Professional Context	Developmental, Behavioural Approach
Planning Strategy	Individualised Planning, Care Plans, Rehabilitation Plans
Priority	Individual skill development, behaviour management
Goal	To change behaviour, skills and competencies

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Social Inclusion Model	
Starting Point	Person as citizen
Target of Change	Community, Environment, Attitudes to disability
Service Settings	Home, Neighbourhood, Local Communities
Dominant Professional Context	Community Development
Planning Strategy	Integrated Local Area Planning and Coordination Multiplicity of Strategies
Priority	Enabling, Accepting Communities
Goal	Social Inclusion/Community Membership

Government Policy Directions

The *Disability Act 2006* (The Act) became operational on 1st July 2007. The Act provides the framework for a joined-up government and community approach to enable people with a disability to actively participate in the community. The Act is underpinned by principles of human rights, self-determination and citizenship and is significantly reforming the disability sector. A rights-based approach is also informed by the *Charter of Human Rights and Responsibilities Act 2006*.

The Act supports quality by legislating disability services' standards, performance measures and compliance through independent assessment and monitoring (*Disability Act 2006 Policy and Information Manual*, July 2009). The introduction of the Quality Framework (QF) and roll out of external assessment for compliance against the QF Standards, is expected to improve the quality of disability support services and enhance accountability to people with disabilities. The QF emphasises the importance of outcomes measurement and continuous quality improvement.

The Changing Days Initiative and Breaking the Mould: Important Changes to Day Services

Outlook's Changing Days and Breaking the Mould projects, funded by the Department of Human Services (DHS), have provided a foundation for implementing structural and systems changes to embed self-directed practice. This has concurrently involved consultation with, and provision of information to clients and carers on self directed funding; and the redevelopment of infrastructure and the model of service delivery to align with the vision of the Victorian State Disability Plan 2002-2012 (State Plan). In essence, this has required the creation of new and more inclusive opportunities for people with a disability accessing Day Services – to enhance their independence, skills, community participation and general quality of life.

The ESC service delivery model outlined herein is designed to take the learnings from these projects as a basis for trialling and embedding a preferred, viable and effective self-directed service model for its Day Service program.

Proposed ESC Model and Structure

The new ESC service model key elements, include:

- ⇒ Development and trial of a new enhanced service model (based on learnings from Changing Days and Breaking the Mould)
- ⇒ Service and staffing restructure
- ⇒ Revised Position Descriptions
- ⇒ Practice Guidelines
- ⇒ Training
- ⇒ Consultation (supported transition)
- ⇒ Documented Service Model, including outcomes of trial to contribute to evidence-base

⇒ Participation in networks of other organisations trialling a new ESC model.

Key Service Model Elements:

⇒ Core base is the community (greater knowledge of local community = greater knowledge of choices)

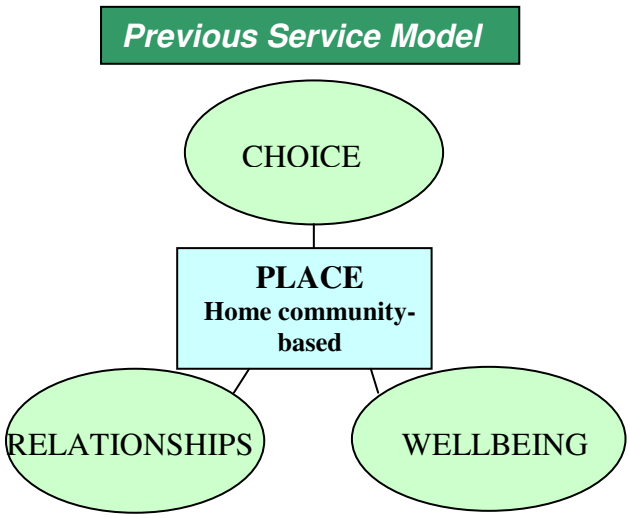
⇒ Move from 'group choice' to 'individual choice'

⇒ Group sets 'norms' for behaviour (incidents dramatically decreased)

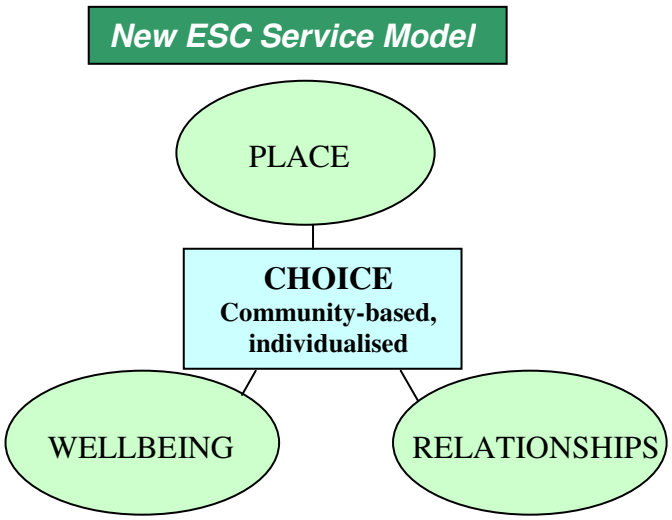
⇒ Partnerships between the person with a disability, their carers, service providers, businesses and the community

⇒ Ongoing consultation.

The philosophical underpinning has shifted from an emphasis on 'PLACE' to 'CHOICE' as depicted in the following diagram.



This model was established as 'place' focussed - moving clients from the traditional Disability Service setting into their home communities providing access to local facilities and activities.



The new ESC model is 'choice' focussed – developing communities to be accessible and accepting, with an emphasis on person-centred, strengths-based and self-directed community inclusion.

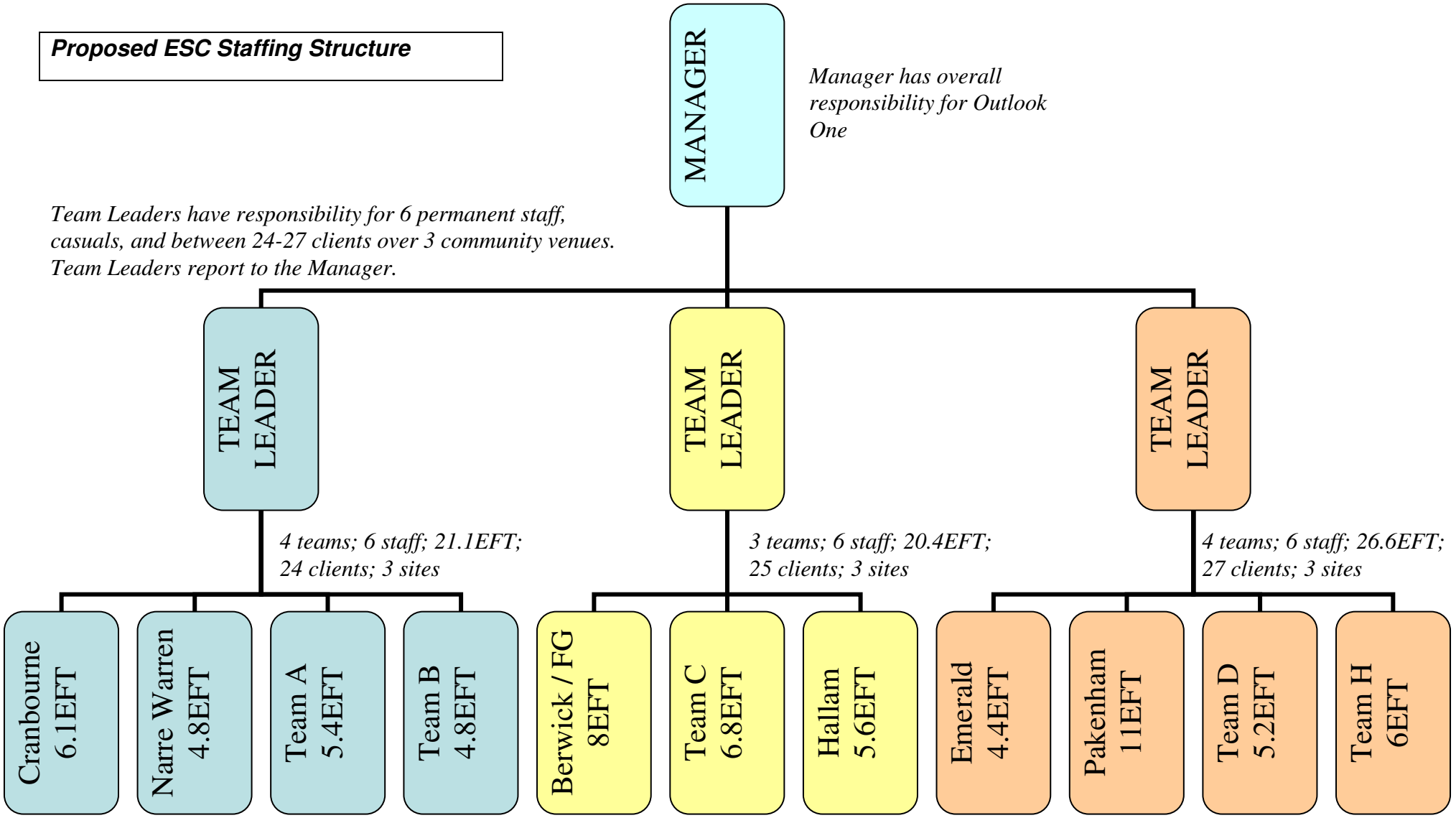
In order for this approach to be successfully integrated, it is necessary for an all-of-agency shift in thinking and practice, including:

⇒ Applying a strengths-based mindset not only to clients, but to ourselves, our team, carers, and the broader Outlook community

⇒ Ensuring every interaction is based on principles of:

- Social justice
- Respect
- Transparency
- Self determination and direction
- Sharing of knowledge, skills and resources
- Recognising people's strengths and resourcefulness.

Proposed ESC Staffing Structure



Section 2: Practice Guidelines

Assistance with Planning and Support Plans

Definitions

Support Plan: is required where a person is in receipt of an ongoing disability support. A Support Plan describes a person's goals and strategies, and describes how the support from the disability service provider is intended to address those goals.

Planner: a planner provides extensive assistance with planning, and works with a person (in most circumstances) ***prior to*** the person being in receipt of any disability-funded supports. A planner supports a person to plan broadly for their aspirations, goals and needs.

Assistance with planning: supports a person to identify their goals, needs and aspirations and the range of informal, community-based and disability supports that may assist them to meet their identified goals. Assistance with planning may be limited (provided by the Department of Human Services or a disability service provider) or extensive (provided by a planner) and, in most circumstances, takes place as a person first enters the disability service system.

Guiding Principles for Planning

The Act outlines an approach to planning that reflects the reorientation of disability services. Under the Act, planning takes place within the self-directed framework and is about self-determination, community membership and citizenship. This is achieved by working with people with a disability to plan and, where required, acquire support that is flexible and enables them to pursue a lifestyle of their choice.

Section 52 of the Act provides guiding principles for planning (refer to appendix 1).

To see the Disability Services Planning Policy in its entirety, go to:

http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/disability-services-planning-policy-2009

The legislation describes two key areas in relation to planning with people with a disability:

- **Assistance with planning** (**limited or extensive**) is provided to assist people with a disability to identify their goals, needs and aspirations, and the range of informal, community-based and disability supports that can assist them. Assistance with planning is proactive and takes place, in most circumstances, as a person enters the disability service system, prior to the receipt of disability supports. It is also available to a person who is already in receipt of disability supports and who is at a point of significant change in their life, needing an extensive planning process to identify new goals, needs or aspirations.
- **Support Plans** are required for any person in receipt of ongoing disability support. Support Plans document a person's goals and needs and how the disability service provider(s) will support them to meet those needs.

Assistance with Planning

1. Assistance with planning:
   - is a **proactive approach** that is undertaken with people with a disability and their families
   - assists a person to **plan earlier** and build strong **links with the community**
   - **supports a person to identify their goals and needs** and the range of informal, community-based and disability-funded supports required to meet those identified needs.
2. Assistance with planning takes place without reference to any required support responses, enabling a person to develop a vision for the type of life they would like to lead. The degree of assistance with planning required by an individual will depend on the person's needs, and may be limited or extensive:

- **Limited assistance with planning** includes assistance to enable a person to identify their goals and needs, information provision and referral to services and supports (for people with a disability or their family members who have already considered some of their needs and goals, and require information and some assistance). This is provided by any disability service provider.
- **Extensive assistance with planning** includes both assistance to enable a person to identify their goals and needs and significant support to build a person's informal networks, link them into the community and build the skill and capacity of people with a disability and their networks (primarily to people with a disability who are seeking support for the first time. People suitable for extensive assistance with planning are generally those who are unsure of their specific needs and require more extensive support to explore their needs and goals). This is provided by disability service providers which are DHS funded to deliver planning and/or case management support as one of their core functions and have expertise to develop informal, community and disability-specific responses.

Availability of Assistance with Planning

Where a person asks a service provider for assistance with planning, or where an offer of assistance with planning made by a disability service provider is accepted, the Act states the disability service provider must arrange for the assistance to be provided within a reasonable timeframe, which is **within four weeks from acceptance**.

Making a Referral for Assistance with Planning

1. When a disability service provider is unable to provide assistance with planning, the person with a disability must be consulted and agree to being referred to an alternative provider that has the expertise or capacity to provide assistance with planning. This referral must be made as soon as practicable but **no later than four weeks** from the request or acceptance of the offer to provide assistance with planning.
2. Disability service providers who make a referral for assistance with planning must ensure that the provider to whom the referral is being made has the capacity to respond to the request for assistance with planning, without a subsequent referral

What are the Expected Outcomes of Assistance with Planning?

1. The outcomes of assistance with planning are:
   - an agreed set of **goals**
   - **strategies** for achieving the goals
   - **outcomes** that will show when the goals have been achieved.
2. Where a person is already receiving disability supports, the planner is responsible for ensuring a **new Support Plan** is developed.
3. Where a person with a disability requests a written plan following assistance with planning, this should be documented in a format which is meaningful to the person.
4. Service providers responsible for assistance with planning should keep appropriate records and documentation regardless of a person's preference regarding the development of a written plan.

What is a Support Plan?

1. The purpose of a Support Plan is to:
   - reflect the **goals** of the person with a disability
   - describe how the **support from the disability service provider(s)** is intended to address the person's goals

- include an exploration of the **strategies and resources** required to achieve the goals of the person
- how **outcomes** will be measured.

2. A Support Plan must be developed in line with the guiding principles for planning.
3. A Support Plan is developed under the direction of the person with a disability and their network, where appropriate, and must be flexible and tailored to the needs and wishes of the person with a disability, their family and support networks. The format, content and language of the Support Plan **must** be individualised to meet the needs of the person with a disability.
4. While goals and strategies related to ongoing disability services are the minimum requirement for a Support Plan, consistent with best practice for planning, a Support Plan should also include goals and strategies related to:
   - other disability supports
   - community supports
   - informal supports.
5. A Support Plan **does not** contain detailed information related to how the personal care, health care, or other specific needs of a person with a disability should be met. This information should be recorded in the client's *Personal and Private Information* communication book.
6. Every Outlook One Support Worker is required to initiate the development of an *About Me* profile for clients. The proforma for this profile enables the person with a disability to express the very essence of who they are – their values, beliefs, likes and dislikes, personality, hopes and dreams etc. **The *About Me* profile is to be placed at the front of the Support Plan to provide context. It is to be reviewed annually with the client and significant others.**

When is a Support Plan Necessary?

1. **A Support Plan must be developed within 60 days** of a person commencing support from an ongoing disability service, such as:
   - day programs
   - facility-based day options
   - flexible support packages
   - individual support packages
   - shared supported accommodation
   - residential institutions.
2. Services are considered to have commenced when:
   - A person moves into the accommodation facility.
   - A person commences at a day program.
   - A person is allocated a flexible support package.
   - A person's funding plan for an individual support package is approved.
3. **It is the allocated Support Worker's responsibility to ensure a Support Plan is developed within the 60 days**.

Who Directs the Development of the Support Plan?

1. The development of a Support Plan should be directed by:
   - the person with a disability
   - someone in their network at the request of the person with a disability
   - a disability service provider under the direction of the person with a disability.
2. Both the person with a disability and their service providers have a role in the development and monitoring of the Support Plan and a joint commitment to the strategies included in it.
3. Only providers who are part of the development of a Support Plan can be allocated roles and tasks as part of that Support Plan. If person with a disability chooses not to have a particular provider involved in the development of a Support Plan, then no responsibilities can be attributed to that provider. In this situation, the person with a disability and the disability service provider must determine an alternative process for planning.
4. If a Support Plan is developed by the person with a disability / their network or another provider, then the responsibility of the service provider is met when the Plan is put in place.

When is a Coordinated Support Plan Developed?

1. Where a person is receiving more than one ongoing service, a single Support Plan should be developed unless the person with a disability requests otherwise. Regardless of whether a person chooses to develop one or more Support Plans, the decision concerning what, and how information is shared between providers, remains that of the person with a disability.
2. A Coordinated Support Plan allows all the disability service providers involved in a person's life to understand what the person is trying to achieve, so that they can work together to support the person. All disability service providers **must** ask the person with a disability if they would like a single Support Plan and **must** then work with other service providers to meet their wishes. In this case, the person with a disability, or their representative, may choose to coordinate the process for themselves or request this be undertaken by a disability service provider.
3. Where a number of disability service providers are working together to develop a Support Plan with the person with a disability, it is important that the planning process consider:
   - How the person with a disability can be supported to choose which disability service provider coordinates the process if they, or their family, are not able or wanting to take on this role
   - How the person with a disability can choose which information is provided to, or known by, each disability service provider
   - How changes to the Support Plan will be made and communicated to those involved
   - Who will be involved in monitoring and reviewing the Support Plan.

   (*The Planning Resource Kit and Implementation Guide for Disability Service Providers* outlines additional detail regarding the roles and responsibilities of providers who are selected to coordinate the planning process.)
4. The impact and influence of other plans (where in existence) must be considered and, where appropriate, incorporated into the development or review of a Support Plan to ensure consistency.
5. Where a person is receiving episodic supports such as behaviour intervention services; case management; criminal justice services; Futures for Young Adults; independent living training; outreach support; respite; or therapy, **in addition** to their ongoing disability support, every effort should be made to support the person to have a single plan developed with the goals and strategies of any episodic service included as part of the Support Plan.

6. In order to coordinate strategies for daily living, information that may be included in the *Personal and Private Information* book (with the consent of the person with a disability) include:
   - personal care, such as dressing, bathing, personal hygiene
   - meal assistance
   - health care issues
   - therapy support
   - communication issues.

   Note: This information is not to be included in the Support Plan.

Monitoring and Review of a Support Plan

1. It is critical that the development of a Support Plan includes outcomes and how they will be measured. This supports the person with a disability, and disability service providers to monitor and review the Support Plan.
2. Support Plans for Day Service participants at Outlook must be reviewed **at least once during each three year period commencing from when the Support Plan is first prepared**.
3. Support Plans for Day Service participants at Outlook can be reviewed at any time upon request, and if a person's needs change and this impacts on the resources required, a person's goals are met or change, or strategies need to be reviewed.
4. When developing a Support Plan, it is important to discuss how and when the Support Plan is to be reviewed, and who will be responsible, and record this in the Plan. This is particularly important where more than one disability service provider is involved.
5. The relevant Outlook Support Worker is responsible for ensuring the Support Plan is reviewed in accordance with the timeframe recorded in the Plan.

Termination of a Support Plan

1. The Act states that a Support Plan is terminated when a person with a disability ceases to access ongoing disability services.
2. Where a person with a disability is in receipt of more than one ongoing disability service and terminates one of these services but continues to receive others or start a new service, the Support Plan must be reviewed to reflect this.
3. Where a person with a disability ceases to receive ongoing services from a disability service provider who coordinated the development of the support plan, the person with a disability, and their families and networks, must consider requesting an alternative provider to coordinate the review and monitoring of their Support Plan.

Further Information:

Victorian State Disability Plan 2002–2012
Access Policy
Information and Policy Manual (including Complaints Policy)
Legislation Implementation Guide for Restrictive Interventions
Legislation Implementation Guide for Supervised Treatment Orders
Better services, better outcomes, stronger communities – Quality Framework for Disability Services in Vic
The Standards for Disability Services in Victoria
Support Your Way - Individual Support Package Guidelines and Handbook

Source: DHS (July 2009) Disability Services Planning Policy, Disability Services Division.

Service Delivery Plan

Definitions

Service Plan: is a daily timetable of the client's activities, meeting place, costs, and information for staff.

Support Plan: is required where a person is in receipt of ongoing disability support. A Support Plan describes a person's goals and strategies, and describes how the support from the disability service provider is intended to address those goals.

Functions of a Service Delivery Plan

1. The Service Delivery Plan (SDP) is an agreement of service between Outlook One and the client. It details the activities for the term and associated costs.
2. The costs as described are payable by the client and include a transport fee, admission fee or program fee. Payment of these fees is required on a daily basis. Failure to pay these fees may result in non-delivery of the program for that day.
3. The client/carer/parent is to sign off on the SDP as evidence of agreement with the activities and to pay the associated costs detailed therein.
4. It is the responsibility of the staff member developing the SDP, to ensure it reflects the combined goals of clients within the specific group as detailed in their Support Plans.
5. The SDP is to be developed in line with the service model and principles outlined in these Practice Guidelines, to ensure the intent of the SDP is aligned with a self directed approach.
6. Any amendments made to the SDP are to be detailed in the template. The SDP is to be reviewed each term in line with client feedback and Support Plan needs.

The file path to access a Service Delivery Plan template is: S:Drive/Community Services/Outlook ONE/Templates/Service Plan

Assessing Risk

Definitions

Risk: The potential or actual negative or positive consequences of an action or event; a hazard, danger, liability or vulnerability to human or property.

Risk Assessment/Management: The process of identifying, assessing, communicating and controlling risks, and making informed decisions that balance the risk with the benefit (calculated / measured risk).

Principles

(DHS, Day Services Policy June 2008) principle:

In accordance with the Disability Act 2006 and DHS Day Service Policy (June 2008), Outlook must:

> *Provide services and supports in a way that reasonably balances safety with the rights of persons with a disability to choose to participate in activities involving a degree of risk.*

Risk Assessment Procedures

1. In line with Support Worker Position Descriptions, it is the worker's responsibility to:
    a. Ensure they have knowledge of Outlook's OH&S systems (when in doubt, ask your supervisor)
    b. Identify, mitigate and manage risks in service delivery, where there is a change in circumstances (eg. new client) and new environments (diverse community settings)
    c. Ensure community venues including workplaces are assessed and deemed safe, prior to allowing a client or group of clients to participate in the activity/training/volunteer work or work experience etc.
    d. Report all incidents, potential risks and near misses to the line manager in accordance with policy
    e. Ensure the recommendations of all risk assessments - individual client, community venue and workplace are followed, and appropriate support is provided to the client.
2. As part of the support planning process, the needs of clients are to be re-assessed in the context of capacity to reduce intervention and support (both formal and informal) to in turn, increase independence. Seek the advice of your Team Leader when assessing risk, it is diligent practice to seek out another professional opinion.
3. Individual client risks are to be documented in the client's case notes and discussed with your team leader at supervision and as necessary.
4. Community venue risks are to be documented in Outlook's Risk Assessment template and shared with the larger staff group at team meetings and staff meetings.
5. Workplace and community risks are to be documented in Outlook's Opportunities for Improvement (OFI) template and presented at staff meetings and management meetings for awareness and action.
6. Risk management is a part of all Outlook governance and operational position descriptions, involving a pre-emptive approach to identifying and mitigating potential risks and hazards.

Behaviours of Concern and Risk

1. In some circumstances, additional short term funding may be needed to address the support needs of people who:
   - Display behaviours of concern
   - Have a mental illness and may require assistance with the management of particular episodes
   - Are at risk of being suspended or excluded from a program due to their behaviours
   - Require short-term additional support due to an illness or post surgery recovery*.

   For example, purchasing of behavioural intervention services from a psychologist may reduce the behaviour of concern and risk. Ask your Team Leader for advice if you are concerned that a client is a risk to him/herself and/or others.
2. Suspension or termination of services to clients is a last resort and is only appropriate if the person:
   - Has an infectious disease
   - Displays persistent behaviour for which behavioural intervention has proven to be unsuccessful and which presents an unacceptable risk to the safety and well being of the person themselves and/or other people
   - Displays persistent destruction of property for which behavioural intervention has not been successful and presents an unacceptable risk to themselves or any other person†.

DHS Incident Reporting Requirements (excerpt from DHS Incident Reporting Instruction, March 2008)

1. Outlook's direct service staff member responsible for the client at the time the incident occurred or when it was reported, must respond to the immediate needs of the individuals involved and re-establish a safe environment.
2. The most senior member of staff available at the time of the incident must report it immediately to their supervisor.
3. The incident report must be completed by the most senior witness to the incident, or the person whom the incident was reported, if there were no witnesses. The incident report form can be downloaded from the department website at http://knowledgenet/hrb/incident/index.htm or the Funded Agency Channel https://fac.dhs.vic.gov.au
4. The coordinator, line manager, CEO, program manager must:
   a. Record the local action in response to the incident and if appropriate, the action planned to prevent recurrence on the incident report.
   b. Quality check the incident report ensuring the appropriate incident type, category, client and location details have been recorded.
   c. Verify the above two steps have occurred.
   d. Submit the form to the relevant department regional office using the designated fax number in accordance with the set timelines.
5. It is acknowledged that the need to quickly submit the incident report may conflict with the time required to develop long-term or complex responses. In this instance, the incident report must be submitted in

* DHS Day Service Policy, June 2008
† ibid

accordance with the set timelines, noting on the form that a response is still being developed. That response must be completed within **five working days** and appended to the original incident report.

6. The appropriate departmental program manager (including, but not limited to the disability accommodation manager, disability partnerships manager, child protection manager) must quality check the incident report ensuring the appropriate incident type, category, client and location details have been recorded. In addition they will review the action taken in response and record any further action required. If any changes are made to the incident report, the modified version must be returned to the reporting officer or organisation for inclusion on the clients file. The Senior Regional Program Manager or Director, Youth Justice Custodial Services will verify the category two, and where appropriate, category three classification.
7. Once an incident report has been completed, the description of the incident must not be changed, amended or altered in any way or for any reason. Occasionally, other witnesses or individuals may disagree with the content of the report. Where this occurs, the alternative views must be put in writing on a separate piece of paper, and attached to the completed incident report.
8. If the incident report has come directly to the Regional Director, copies must be provided to the relevant Program Manager and PASA.
9. If the Regional Director determines that a report submitted by a CSO or direct care service as category one is in fact category two (or vice versa) the CSO/direct care service will be advised of the re-categorisation.
10. Once the incident report is verified and endorsed, copies must be placed on the relevant client or staff files.
11. The incident report form should record all necessary factual details. It must include:
    a. who was involved
    b. how, where and when the incident occurred
    c. who was injured and the nature and extent of injuries (if applicable)
    d. what action is being taken in response to the incident.

    Objective language must be used.

For a complete copy of the DHS Incident Reporting Instruction, go to:

https://fac.dhs.vic.gov.au/publicfolder/publications/DHS/policies/IncidentReporting/2008/Incident-Report-Instruction-March2008.PDF

Behaviours of Concern - Office of the Senior Practitioner Guidelines

Definitions

Behaviour of Concern (BOC): Formerly referred to as 'Challenging Behaviour', BOCs are presentations of concerning behaviours which may be caused by medical, psychiatric or environmental factors, and require identification and implementation of supports and actions to address the concerns.

Examples of behaviours of concern may include behaviours that present as:

- Aggression
- Property destruction
- Self injurious behaviour
- Socially inappropriate behaviour
- Withdrawn behaviour.

NB: A person that engages in illegal behaviour should be referred to as such, and not misconstrued as a behaviour of concern.

Behaviour Support Plan (BSP): referred to in The Act as a 'Behaviour Management Plan', the BSP is a plan for appropriately managing behaviours, with an emphasis on positive solutions in practice.

Restrictive Intervention (RI): chemical restraint, mechanical restraint, seclusion, physical restraint.

The Disability Act 2006 states that:

- The disability service must have approval to use restrictive treatments
- The person's Behaviour Management (Support) Plan must include any use of restraint and seclusion
- An independent person must discuss the treatment with the person with a disability and advise them of their rights
- The Office of the Senior Practitioner must review all Behaviour Management (Support) Plans
- Requests are to go to VCAT to review decisions
- Quality standards are to be met (Industry and Outcome Standards)
- Restrictive interventions and compulsory treatment are to be delivered in line with the legislation.

Purpose of the Office of the Senior Practitioner (DHS, April 2008)

Summary Role:

- Responsible for ensuring the rights of people with a disability subject to a restrictive intervention or compulsory treatment are protected
- Provide information, advice to improve practice, directions, evaluate, monitor and make recommendations to disability service providers, people with disabilities, Minister and Secretary.
- Receive Reports on the Restrictive Intervention Data System, collate information and review all Behaviour Support Plans
- Under section 27 of The Act – investigate, review, audit or direct a disability service provider to cease or alter a practice, procedure or treatment.

Strategies:

- Chemical restraint reduction strategy
- Assessment – Behaviour Support Plans based on support strategies that are positive and not punitive, related to addressing behaviours of concern, and are clear, succinct and take into account the person's likes and dislikes
- Regular review and evaluation moving toward positive strategies and solutions

- Individualised strategies based on person's strengths
- Coordination of services – one person, one plan
- BSP individualised according to person's communication needs
- All disability services appoint an Authorised Program Officer (APO)
- An independent person must be present when communication of BSP is discussed/communication with the person with a disability recipient to restrictive intervention
- BSP must ensure continuing quality improvement ensuring a cycle of assessment, implementation, monitoring and evaluation
- APO must hold a senior position of authority within an organisation and wherever possible be independent from immediate operational management of the residence of the person who is subject to restrictive interventions
- Have a comprehensive understanding of the responsibilities of the APO as defined in the Act
- Have knowledge of the environment in which it is proposed that a restrictive intervention or compulsory treatment is being applied
- Understand the purpose of behaviour management plans and have knowledge of key elements of an effective plan
- Ensure RI is reviewed on a regular basis, by relevant professionals and that independent monitoring occurs.

Practice Guide to Behaviour Support Plans

The term Behaviour Support Plan (BSP) has been chosen by the Office of the Senior Practitioner to reflect current best practice and also to reflect the intent of these plans – to support the person with a disability. People with disabilities that have been assessed as having Behaviours of Concern must have a BSP.

Required Inclusions in Behaviour Support Plans:

- Assessments (functional behaviour assessment)
- Positive Behavioural strategies that target behaviour/s of concern
- Strategies written in positive wording to positively impact on behaviour of concern (strengths-based)
- Description of how the restrictive interventions should be used and when, how and who will review BSP
- People with a disability who have Behaviours of Concern are consulted.

BSP KEY ELEMENT	BSP REQUIRED ACTIONS
Assessment	⇒ Focus on whole of life areas, and not just behaviours of concern or dysfunction. Areas where 'behaviours of concern' are not evident/obvious may become overlooked; assessing such areas might provide important insights into the person's strengths and reasons as to why a problem behaviour is not occurring ⇒ Consider all contexts the person lives or engages in ⇒ Involve key people in the person's life ⇒ Where appropriate and relevant, formal assessment instruments should be used.
Planning and implementing interventions	⇒ The BSP must form an integral part of a person's individual Support Plan. It needs to take account of support needs across all settings, and be collaboratively developed in consultation with all key person's involved in the person's life. ⇒ Where appropriate, a BSP could be a stand-alone plan, however, needs to take account of whole of life areas and need (for example, within a respite setting, where a person may only attend a respite facility once a month over a weekend, a BSP may be developed for the purpose of addressing the need to administer a prescribed PRN medication, or some other form of restrictive intervention) ⇒ Each context to which the BSP applies needs to be involved in the planning process, and strategies to be implemented in each setting clearly identified with clear rationale/clinical reasons described.

Monitoring and analysis of interventions and documenting outcomes	⇒ Continuous monitoring of the strategies/intervention being implemented and their impact on behaviour/behaviour change needs to be undertaken and documented regularly (perhaps daily, if warranted) and accurately. Analysis of data evidence is important to identify success or lack of success in implementation. This area is one that is quite often neglected, due to operational and logistical issues such as staff and shift changes, varying policies, procedures and processes that apply in different settings. Staff need to be trained in collecting and documenting data. ⇒ Good communication processes across all settings needs to be established and consistent. Communication should include positive feedback to the person with a disability where positive changes or improvements are observed.
Review	⇒ The review of the BSP should aim to use the information gathered from continuous monitoring and analysis to determine whether the BSP and proposed strategies/interventions continue, cease and/or require re-assessment and further planning of interventions. ⇒ The BSP should be reviewed regularly and/or as and when required (for example, with changes in circumstances such as living arrangements, vocational/social activities etc; or, at intervals directed by the Senior Practitioner or the Authorised Program Officer). ⇒ The review process should feed into a well structured and planned 'feedback loop', which involves all key persons in the person's life and who might have contributed to or were consulted on different aspects of the BSP (if appropriate to do so after considering privacy and confidentiality issues/implications).
Evaluating Outcomes	⇒ The outcomes and their success/lack of success need to be evaluated in light of the original assessment (where possible), and be discussed and considered with the person with a disability and his/her family or carers/significant others, as relevant and appropriate. ⇒ Evaluating outcome success needs to consider improvements to quality of life in all areas - not just reduction in 'problem behaviour'. The areas to evaluate using evidence of improvement may include: o Community connections (not just frequency of access, but meaningful engagement and participation in community life) o Employment and recreational opportunities o Social relationships (for example, quality of relationships with co-workers at supported employment; staff - resident relationships etc) o Participation and success in daily life, routines and activities o An appropriate Quality of Life instrument to measure outcomes is highly recommended.

For further details and a BSP template, go to:

http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/152762/osp_bsp_practice_guide_2007.pdf

For further details on restrictive interventions and an application form template, go to:

http://www.dhs.vic.gov.au/__data/assets/word_doc/0011/152858/osp_restrictive_interventions_2007.doc

Strategies for Resolving Conflict

It is acknowledged that group-based activities whether conducted in a centre or in the community, canlead to disharmony. This can in turn result in aggressive, risky behaviour. Support workers have a duty of care to keep Outlook participants as safe as possible, and participants are responsible for attempting to resolve conflict and minimising behaviours that are disruptive to others or create risk.

1. In line with legislation and the requirements of Office of the Senior Practitioner, restraint and seclusion can only be used:
   - to prevent people from hurting themselves or others;
   - if it is the least restrictive alternative available; and
   - only while the behaviour of concern is present.

   It is Outlook policy that alternative least restrictive interventions always be sought where possible.
2. There are a range of pre-emptive strategies outlined by DHS to reduce the risk of conflict and assault, including:
   - Comprehensive assessment of the history of aggression and contributing factors
   - Assessment of problem solving capacity
   - Training in collaborative problem solving
   - Agreement between the client and worker of appropriate ways to express anger and aggression
   - Strategies devised by the client for implementing when feeling angry or frustrated (eg. diversion, decreased stimulation, talking to a nominated support person, relaxation etc.)
   - Development of a Behaviour Support Plan that is strengths-based. Focussing on doing more of what works, focussing on positive behaviours and interventions
   - Development of an Action Plan to deal with stress that identifies the client's range of feelings; strategies he/she can implement to maintain positive feelings and minimise negative feelings; and strategies the worker can implement to maintain positive behaviours and minimise negative behaviours.
3. There are a range of immediate interventions to defuse aggressive behaviour, such as:
   - Relaxation, meditation
   - Walking or other forms of exercise
   - Music, reading, art, craft, leisure or personal interests
   - Talking with a trusted support person (by phone or in person).
4. It is important that strategies are selected by the client in consultation with significant others (carers may know of some effective methods for resolving behaviours of concern).

For further information refer to: Office of the Senior Practitioner, *Positive Solutions in Practice: From Seclusion to Solutions*
http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/152555/osp_positivesolutionsseclusion_pdf_231007.pdf

Also refer to Outlook's *Conflict Dispute Resolution Procedure*.

Client Files and Case Noting Practice

Definitions

Client: a person who has engaged or is engaged as a direct service user.

Client Files: is a record of client information (hard copy and/or electronic), including personal details, assessment, case plans and case notes for the purpose of service provision. It is crucial that files be maintained in accordance with the Privacy Act 1988 (C'wealth), Information Privacy Act 2002 (Vic.) and Health Records Act 2001 (Vic.).

Case Note: Case notes or records are evidence of an interaction between a worker and client. The case note entry is a documented account of discussions, decisions and actions.

Purpose of Client Files

To ensure a systematic method of capturing, storing and accessing all information gathered per client during their period of service at Outlook. The client file may contain case notes, correspondence, referrals, reports, plans etc. The client file includes case note entries which provide a record of client progress.

Case Noting Purpose

Case noting or case recording is an important aspect of service delivery to:

- Enable critical historical information to form a key part of current risk assessment
- Structure and clarify complex information and interpretation
- Articulate the assessment and rationale behind critical and key decisions
- Provide a record of all contacts and events related to a client, case management and best interests planning processes
- Ensure that important information can be retrieved and understood
- Provide an archival record of events in the life of a child, young person or adult that can be assessed by the person concerned, family and/or new practitioners and others when needed
- Assist in the identification of patterns in client behaviour and service response
- Identify the success or failure of past interventions for future decision-makers
- Form the basis of formal reports[‡].

Case Noting Procedures

1. Ensure all relevant client documentation is completed as required and stored in the client file accordingly.
2. Create, store, transfer and dispose of client files in accordance with the Health Services Act 2001, Information Privacy Act 2000, the Privacy Principles contained in the Privacy Act 1988, and the Public Records Act 1973.
3. Ensure case notes reflect changes to the Service Delivery Plan and Individual Support Plan.
4. Case Notes should consider:
   - The purpose of the event
   - Location of the event
   - Context of the event (eg. time, others present, related activities/events)
   - Key issues discussed or arising

[‡] Department of Human Services Victoria, Advice No. 1094

- Changes to risk assessment or well-being
- Decisions made (timelines, persons responsible, method for communication)
- Action taken or required
- Reference to any other information on either the electronic or the paper file.

5. Case Notes must be recorded professionally and objectively. Practitioners must be able to support everything that is written and verify assessments and any decisions made.
6. Case notes have traditionally been written in third person (i.e. the writer observed, the client appeared…because…), but there is a shift toward first person to enhance worker ownership of assessments and actions (eg. I observed, I assessed…based on…).
7. All case notes must be dated and your name or initials entered.
8. Case notes must be a record of relevant information only (i.e. only that information that is relevant to the provision of service such as family dynamics, relationships, observed behaviours, factual detail related directly to the reason for referral, etc.).
9. The worker must ensure all relevant client issues, including behaviours of concern, are documented in case notes and discussed with their team leader to maximise the most appropriate and effective service response.
10. Case notes must be **recorded within a maximum of three working days** (DHS guideline).
11. The case note of any joint activity must be read and agreed to by both practitioners.
12. **Case note entries must not be amended**. Any new information must be entered as a discrete case note, with a reference to the original case note and its date.
13. Case notes must be recorded in accordance with privacy and freedom of information principles/guidelines, as follows.
    a. That an organisation must not collect health information about an individual unless the information is necessary for one or more of its functions or activities and the individual or legally appointed representative has consented; or the collection is required by or under law; or the collection is necessary to prevent or lessen a serious and imminent threat to the life, health, safety or welfare of any individual; or the collection is necessary for the establishment, exercise or defence of a legal or equitable claim (Health Privacy Principle 1 extracted from the Health Records Act 2001)
    b. That any person has the legal right to gain access to any documentation (other than exempted material) related to themselves (Freedom of Information Act 1982, Part III)
    c. That upon gaining access to documentation, the person granted access has the legal right to correct and update inaccurate factual information recorded about them (Health Privacy Principle 6.5).
14. Clients must be informed of their rights and responsibilities including entitlement to access their own files§, and complaints mechanisms should they feel their privacy has been breached.
15. Where a third party seeks access to the client file for or on behalf of a client, ensure that they are authorised to do so and that any prior authorisation has not been withdrawn.

§ When a client wishes to access their file, ensure:
- The original file remains the property of Outlook
- Two copies are made of requested material (one copy is to be handed to the client and the other copy is to be placed on the original client file, with both copies signed and dated by the client and the worker on each page)
- A staff member is present to supervise the client whilst accessing their file. Do not leave the client alone at any time with their original file. An explanation is provided to the client, as required, in relation to the information filed. This explanation is vital if there is anything in the notes or client file which could be misinterpreted, taken out of context or difficult to understand
- Mobile phones, cameras and/or computers are not taken into the room.

16. The collection, use, storage, disclosure and disposal of information must respect client rights to privacy and confidentiality and be underpinned by informed consent.
17. Where a client has requested their personal information be supplied to another service provider, this must be copied and either couriered, hand delivered or sent by registered mail to the specific worker, and not given to the client to deliver.
18. If a client does not have capacity to provide consent, then an authorised representative must provide the consent to the collection, use and disclosure of the client's information (an authorised representative may include a parent or carer, a court appointed guardian or a guardian under an enduring power of attorney, etc).
19. It is a client's right to decide NOT to share some personal information, to restrict or refuse access to their client file, or withdraw consent during the period of service. In these instances, it is the responsibility of the worker to inform the client that this decision may affect Outlook's ability to provide the best possible service. This is important to ensure the client understands and their decision is informed.
20. Ensure that refusal or withdrawal of consent is noted in the case notes; and that verbal confirmation of the potential for reduced service capacity is also noted in the case notes.
21. There may be occasions where it will not be in a client's best interest for privacy to be maintained. Disclosure is required by law (for example) to prevent serious and imminent threat to an individual's life, health, safety or welfare (check with your manager regarding the procedure for disclosure).
22. All client documents must be kept in locked cabinets with access restricted to authorised staff and management.
23. All data stored electronically must be password protected.
24. Client hard copy and electronic records (including case notes) can only be taken off-site if transported in a lockable case. The lockable case must be transported in the boot of the car. If the worker stops briefly, the locked case must remain in the possession of the worker at all times.
25. Client information is not to be accessed in the home environment where other people may view this information.
26. Original client files must always remain the property of Outlook. The only exception to this rule is if the original file is required by a court of law, in which case the entire file must be photocopied, with the copy retained by Outlook and the original securely forwarded to the Court Registrar.
27. It is good practice for case notes to be audited to ensure consistent, good practice procedures are being implemented. The Outlook One Manager is responsible for initiating an annual audit process.
28. It is the worker's responsibility to constantly seek to review and evaluate all aspects of service delivery as a means of identifying areas for improvement.

<u>Sources:</u>
DHS website
Information Privacy Act 2000
Health Records Act 2001
Freedom of Information Act 1982
Charter of Human Rights and Responsibilities Act 2006

Self Directed and Individualised Supports

Definitions

Self-directed Approaches: People with a disability and their supporters are able, in line with their personal circumstances, to plan for, determine and subsequently purchase the supports they believe to be most relevant to their individual needs and preferences.

Personalised Supports: Supports that are developed specifically by and for the person. This means that, in line with the informal supports and funding available to them, the person can determine the activities they participate in, the time of day or week the supports are required, and whether they share the supports with anyone else.

Principles

The three main elements of self-directed approaches are:

- Self-directed planning
- Self-directed funding
- Self-directed support.

In order to truly embed a self directed approach to planning and implementing individualised supports, we must:

- Recognise that the person with a disability is at the centre of all planning, funding and support responses relevant to their individual lifestyle aspirations, age and culture
- Consult, support and inform clients, families and colleagues resistant to change, through the transition to a self directed model of service delivery (consultation and consumer feedback)
- Ensure that communities are welcoming and inclusive (undertake joint work with other providers, government, businesses etc. to build community capacity)
- Enable people with disabilities to actively and meaningfully participate in a range of socially valued roles, interactions and activities in the community.

Self Directed Planning/Support - Recommended Practices

Individual level

1. Ensure the person with a disability is central to planning their supports and activities (see *Assistance with Planning and Support Plans* section*).*

2. Work in partnership with clients and their carers, recognising the person with a disability as being the central driver of support planning. Ensure supports and activities are individualised and in the client's community (or other environment) as indicated in their Support Plan; and that the level of client support provided is re-assessed on a regular basis with the goal of increasing independence.

3. If a restriction on rights or opportunities is necessary, ensure the selected option is the least restrictive (see *Behaviours of Concern* section*).*

4. Ensure activities advance inclusiveness and participation in the community in addition to allowing individuals to work toward achievement of their Support Plan aspirations (you are an Outlook advocate for promoting self direction and building community capacity).

5. Ensure that your approach as a Support Worker is adaptable and responsive to changing needs, and maximises choices that enhance independence.

6. 'One size does not fit all', so ensure you adopt different practices to suit different types of disability and life stages. Similarly, be aware of any potential increased disadvantage that may be experienced as a result of gender, language, cultural or indigenous background, or location. Plan with the client how these potential areas of disadvantage could be addressed.

7. Link clients into training or other opportunities that will improve their skills and confidence in making decisions. As the Support Worker, you may be instrumental in assisting the client to build these skills. Building confidence and independence is key to self direction and inclusion (eg. asking: What would you like to do? Do you think we should do x or y? What do you think we should take with us? When should we leave? etc.).

8. Identify social, learning and recreational opportunities within the client's home community as a starting point – to build relationships with local service providers, businesses etc. and confidence in navigating the local community, as a stepping stone into other communities. Utilise the knowledge and resources of your colleagues, local government, networks and other community/business links to find out what is available.

9. Recognise that you have responsibility for the quality of the service provided, and as such, you must monitor the service, report any concerns to your supervisor and actively seek opportunities for improvement in collaboration with the client and his/her nominated advocate (see *Continuous Quality Improvement* section).

Community level

1. Respect, acknowledge and strengthen the capacity of families and significant others in the life of the client, as these informal supports can be pivotal in enabling community access (i.e. through accompaniment, transportation, practical assistance), thereby building confidence and independence.

2. Create links with the advocacy sector to learn how as a worker you can empower people with disabilities to have a strong public voice on a wide range of matters, including areas of disadvantage. Ensure you have contact details for, and knowledge of advocacy and lobby groups/forums for appropriately linking clients.

3. Seek opportunities to develop formal and informal pathways into mainstream and specialist support services. The development of protocols detailing how the referral pathway will function, is a fundamental agreement between both organisations which can improve consumer access.

4. Seek opportunities for collaboration (partnership, joint teamwork), coordination (joint planning and implementation) and integration with other local services. These linkages between organisations aim to improve access and outcomes for consumers.

5. Encourage clients to establish, build on and maintain relationships in their local community with community groups, businesses, support services, recreational facilities etc. Not only can clients help to raise awareness of the capacity of people with disabilities broadly, they can have a direct impact on the community's responsiveness to their needs.

Individualised Funding

1. Individualised funding prevents a particular disability service provider from exercising control over all or most aspects of a client's life. Individualised funding enables a person with a disability to combine mainstream supports with specialist disability supports that are relevant to their individual needs.

2. People may wish to use their individually attached funding to undertake activities that:
   - are tailored to their specific needs and they undertake on their own; or
   - are tailored to the needs of two people or a small group; or
   - have been designed for a larger group.

3. Support Workers are to work with the person (and any others sharing the activities) to plan how all the activities will be provided. Where a person nominates to undertake one-to-one activities, the costs of this support may affect the group activities previously provided. Support Workers are to explain the potential impacts to those involved and make required adjustments to the Service Plan.

4. When a person ceases to require their funding package for any reason, the funding allocation is to be returned to the region for reallocation. You must notify your supervisor, who in turn will inform the Manager Outlook One, as soon as you are made aware that a client no longer requires their funding allocation.

For further details refer to: Day Services Guidelines 2011: http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/day-services-guidelines

Consumer Feedback

Purpose

Participant feedback is sought regarding their experience as a direct service user and to inform service and system developments. This has been vital during the transition to a self directed service delivery model and will continue to be important in informing service improvements.

Outlook seeks consumer input into planning, and feedback on services through the Outlook Participant Committee, client representation on the Board of Management and client/carer meetings at each of the community venues.

We also gather information from participants based on the Disability Services Standards, using trained volunteer participant interviewers. An independent facilitator is used to train interviewers, arrange interviews and record the comments of participants. The facilitator analyses the data and reports on the outcomes of the survey and on the conduct of the interview process.

Procedures

Training

1. Determine who you need to obtain feedback from (eg. clients, carers, family), the topic (or research question) and timeframe.
2. Determine (based on the target group, topic and timeframe) the most appropriate method for obtaining feedback, including sampling, data collection tools and analysis.
3. You may utilise trained participant interviewers to seek feedback from their peers, or you may wish to seek a new group of interviewers, in which case the following training procedure is to be undertaken.
    a. Send a request throughout Outlook One for interested participants to undergo Interviewer Training.
    b. Select a team of three people including at least one person with previous experience in conducting client satisfaction interviews.
    c. Engage a facilitator to conduct training.
    d. Training currently includes review of interview questions based on the Disability Services Standards. Version A is for participants with verbal communication skills and uses open questions. Version B is a set of questions allowing a yes/no response for people without verbal communication skills. The interview is supported by access to visual aids to assist communication.
    e. Interviewers are trained in questioning techniques, the necessity for confidentiality in relation to the information they hear, and not to offer any comment on information given by interviewees. Only trained interviewers can be part of the interview team.
4. A request for volunteers to be interviewed is to be circulated throughout Outlook One. Interviews and transport are to be arranged by the facilitator as needed.
5. At the interview, the facilitator is to introduce the interviewers, explain the purpose of the survey, the role of the interviewers and the facilitator, and clarify how the information obtained from participants is to be utilised.
6. The Interviewers are to then ask their questions. The facilitator is seated to the side of the interview process and records the comments made.

7. Comments must be recorded accurately. Any clarification or recording of a strong emotional response offered by the facilitator should be in brackets, so as not be confused with a participant's response.
8. Participant's are to remain anonymous – their names must never be recorded against a comment.
9. The facilitator is to read back what has been recorded following each question to confirm accuracy by participants.
10. Interviewees are to take turns in asking questions, and repeating the questions slowly if necessary.
11. At the end of the interview, the interviewees are to thank the participants, and the facilitator is to reiterate to all those involved, how the information is to be used.
12. The data is to be recorded and analysed and a report developed on the outcomes. Interviewers are to be asked to read and/or listen to the report to validate that it is a fair record of the events, and to sign off on the bottom of the report.
13. A second report is to be made on the process and conduct of the interviews, including recommendations for improvements, and this is to be read to the interviewers.

Tips on collecting information from Outlook participants

1. Good practice is to provide a range of feedback methods, including pictorial, auditory and written in hard copy and electronically (including web-based). Outlook will be looking into developing these systems further, however in the meantime, Support Workers may be able to access some basic tools through peak bodies, networks etc.
2. Participants have a right to their own opinions, and interviewers must be non-judgmental and honest in their recording.
3. Participants tend to be more open when talking to other participants and less open with unfamiliar people.
4. Verbal questioning is more effective than reading questions.
5. Small interactive groups chatting informally tend to be more effective in collecting quality responses, and participants appear to prefer this method of data collecting.
6. Repetition of questions quietly allows participants thinking time and clarification if necessary.
7. If you are planning to engage an alternative method to interviewing, ensure you reduce the number of questions.
8. If a participant is difficult to understand, other participants may be able to interpret for the facilitator. Remember to get the participant to confirm that the comments being recorded are accurate.
9. Participation in the client feedback activities must be voluntary, not nominated.
10. The Outlook Participant Committee is an excellent resource for obtaining input into planning and improvements. If you need client feedback on a specific matter, have the item placed on the agenda for deliberation.
11. If you need to obtain information from Outlook clients and their carers, you can arrange a meeting at your group's primary community venue and conduct a focus group (a guided discussion to find out opinions), workshop (presentation on a specific topic but with active participation by attendees), or interviews. Seek guidance from your Team Leader and approval from the Outlook One Manager before proceeding.

Community Capacity Building

Purpose

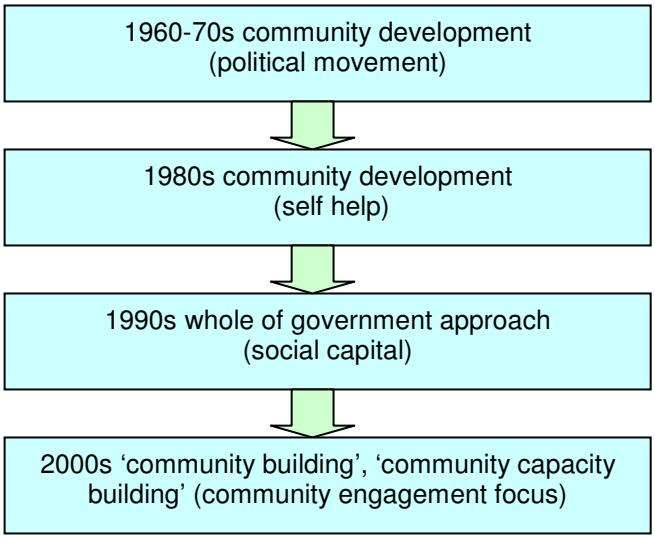
The Community Building Program within Disability Services, identifies a key goal of the *Victorian State Disability Plan 2002-2012* as being to 'build inclusive communities' *(in Supporting self-directed lifestyles for Victorians with a Disability, 2009)*. The Community Building Program (known locally as Rural Access, Metro Access and Deaf Access) was established to enhance a community-based approach.

"People with a disability in Victoria have told us that they feel apart from, rather than a part of their community" (Department of Human Services 2000, *The Aspirations of People with a Disability within an Inclusive Victorian Community* as cited in Community Building Program, 2009:5).

Creating truly inclusive communities involves a partnership approach between people with a disability, their families/carers and their communities, government departments at all levels, specialist supports, disability providers, mainstream community organisations and local business - in order to build respect, value and citizenship.

Definition

Paul Bullen (March 2007) eloquently describes the shift from community development to community capacity building as follows (summarised):



Bullen (2007) identifies alternative terms for community development to include: community of place; community of interest; community development; community building; community capacity building; community organising; and community engagement.

The Victorian Government refers to community building as community strengthening, which it defines as follows.

> *Community strengthening is a sustained effort to increase involvement and partnership among members of a community to achieve common objectives. It involves local people, community organisations, government, business and philanthropic organisations working together to achieve agreed social, economic and environmental outcomes.*

The Community Building Program (2009) identifies that community membership and inclusion is achieved when self directed planning, self directed supports and community building strategies are put into place.

Key Principles

The principles underpinning a community building or community strengthening approach, include:

⇒ Understanding that all people have valuable contributions to make to their community

⇒ Making communities stronger by building on their existing assets

⇒ Respecting the diversity of people

⇒ Involving communities in decisions which affect their lives

⇒ Building better connections between community groups, businesses and government

⇒ Giving people equal access to information and services.

Values and attributes needed to be an effective community-based worker

Outlook Support Workers have identified the underlying values and attributes for the role in line with the shift to a self directed approach. Centre-based work tended to be more structured, predictable and hands-on (carer model), whereas the community-based worker is required to be flexible, adaptable to changing needs and a coordinator rather than a 'doer'.

Support Worker Profile:

⇒ Community development / facilitation role

⇒ Innovative, resourceful and flexible (able to improvise at short notice if community activity is cancelled)

⇒ Empowering value base (inclusive, rights-based, person-centred approach)

⇒ Reliable, contactable and available

⇒ Organised

⇒ Good communicator and listener

⇒ Ability to respond to unexpected events using common sense

⇒ Work independently (capable)

⇒ Relaxed approach rather than authoritarian

⇒ Previous work experience

⇒ Active, and enjoy the outdoors

⇒ Understanding of parents

⇒ Awareness of a broad range of disabilities (especially triggers for behavioural issues)

⇒ Respectful and aware of noise levels, behaviour and privacy

⇒ Empathic (what would I want?)

⇒ Ability to undertake a needs assessment and follow through with implementation

⇒ Focussed on developing independent living skills.

Community Building Strategies

1. Your role as a Support Worker at Outlook includes strengthening the communities of which Outlook clients are a part – to build awareness of the right and capacity of people with disabilities to be contributing, valued members of society. Outlook Support Workers, as part of the Changing Days Project Evaluation 2010, identified that the focus of their role has shifted from carer to community networker.

Specific strategies to build the capacity of the communities Outlook clients live in and access, are as follows.

⇒ Link clients into activities within their local communities that will advance achievement of the goals in their Support Plan, enable familiarisation with their home community and the people within, and offer a familiar platform upon which to build skills and take calculated risks

⇒ Promote the right of people with disabilities to choose to participate in activities involving a degree of risk (enhance access through increasing awareness and reducing over-cautiousness)

⇒ Create opportunities for skill development through applied learning, training, and volunteer work

⇒ Initiate, and empower clients to initiate and sustain relationships with community members, transport operators and local business owners – build personalised relationships / connections

⇒ Take a lead role in raising awareness of access issues for people with a disability, principles of inclusion, and the strengths of people with disabilities when negotiating arrangements with venue operators, businesses and community partners

⇒ Adopt a strengths-based approach – focus on what clients can do and what communities do have to offer. Build on these strengths and opportunities and do more of what works! This is also known as an 'assets-based approach' which works with and builds on the strengths of a community

⇒ Involve yourself and clients in local planning activities / consumer networks – to have a voice, be heard, advocate and influence local decision making

⇒ Encourage the communities Outlook clients live in and access (as a starting point) to initiate change in the planning and development of activities and infrastructure so that it is accessible (physical environment and information) and inclusive for ALL people (note: lobbying requires approval from the Outlook One Manager)

⇒ Utilising the goals of your group (combined Support Plan Goals in Service Delivery Plan), brainstorm the range of skills and resources needed to meet client needs, and create strong partnerships**

⇒ Identify opportunities for building on these partnerships in a more formal way (based on goodwill and underpinned by a clearly articulated purpose) such as a joint initiative, funding opportunity, support arrangement etc. (note: seek approval from the Outlook One Manager before embarking on any formalised venture)

⇒ In regard to linkages with local service providers, community organisations, local government and businesses:
  - Establish relationships where these links do not exist
  - Strengthen these relationships where they do exist, but require further development
  - Continue to seek opportunities for developing new relationships
  - Sustain strong relationships through maintaining contact, reciprocating favours and resources and joint planning/activities (with permission of your supervisor).

** Arrange to have yourself placed on a mailing list or invitation to an event; cold call the person you want to establish a connection with and arrange to meet (coffee and an informal chat is a good way of establishing a connection); have a mutual acquaintance introduce you.

- ⇒ Support Workers develop their program of activities based on local options sourced via mailing lists, community booklets, council brochures, community centre programs, library programs and networks / partnerships
- ⇒ Place yourself on mailing lists, local networks and planning forums to meet and greet and establish connections
- ⇒ Identify opportunities for matching clients with community organisations, businesses etc. to increase community participation and build a suite of mainstream support options
- ⇒ Promote projects that advance community inclusion for people with disabilities
- ⇒ Identify the priorities for advancing inclusion and access in the communities Outlook clients frequent, document these and work with Outlook management to bring about change
- ⇒ Identify cross-promotional opportunities with other providers and businesses eg. stall at market, information booth at shopping centre etc.
- ⇒ Link in with specialist support services and community groups when working with clients from diverse cultural backgrounds (CALD, Aboriginal, GLBTI[††], mental health etc.) to create/build on links that people with disabilities have with their own cultural/language group. You may need to educate this group on the capabilities of people with disabilities (be sensitive in your approach).

2. Outlook encourages Network involvement, however before joining any networks, planning committees, decision making forums etc. you must seek approval from the Outlook One Manager. This prevents duplication and enables management to determine the value of investing your time in the activity.
3. Any formalised partnership arrangement must only be entered into on behalf of Outlook with the prior written approval of the Manager Outlook One.
4. Similarly, lobbying activities must only be undertaken on behalf of Outlook with the prior written approval of the Manager Outlook One.

[††] Gay, Lesbian, Bisexual, Transgender, Intersex

Secondary Consultation

Definition and Purpose

Secondary consultation is a meeting of professionals to provide advice, support and discussion in relation to casework, theory and/or practice. Its purpose is to improve client outcomes through:

- Sharing knowledge, skills and resources
- Professional development
- Joint problem solving
- Planning for a collaborative service response
- Multidisciplinary networking
- Challenging conventional thinking.

Procedures

1. Responsibility for hosting secondary consultation is to be rotated among each of the three Support Worker teams, with topics identified by team members, and invitations and facilitation organised by the respective Team Leader.

2. The Manager Outlook One will support secondary consultations by:
   - developing and distributing an annual roster for teams (including dates)
   - supporting non-client contact time for representatives from each team and other services/programs across Outlook to attend
   - ensuring (where relevant) new staff are linked into this process.

3. The Team Leaders will:
   - liaise with each other to ensure a coordinated approach
   - arrange bookings of meeting space in advance
   - liaise with external stakeholders to attend/present (determined by the nature of the topic)
   - distribute the annual roster via email
   - facilitate secondary consultations
   - remind attendees to uphold privacy and confidentiality during, and as a result of all discussions.

4. Within the annual roster, teams will be nominated to present a case, research evidence or discussion topic. Team leaders will determine the suitability and relevance of topics to the wider staff group.

5. It is the team's responsibility to distribute an outline of their presentation to the Manager Outlook One who will approve it and forward on to other participants.

   a. Case presentations must:
      - be de-identified
      - provide case background
      - articulate topics for discussion.

   b. All case related documentation that is supplied prior to and during a forum, must be deposited in the centre of the table prior to leaving, to enable collection and secure disposal by the Team Leader, thereby upholding privacy.

   c. Research papers that are presented are to be referenced.

Professional Development

Definition and Purpose

Professional development of Outlook's Support Workers is an ongoing process of training, skill development and mentoring. Individual professional development needs will be identified by a worker's supervisor during supervision sessions. Where there is a common training need across Outlook One, a training program will be facilitated either internally or externally for all staff.

Training Topics

1. Training is to be facilitated in small groups (team based) of no more than 10 (including casuals) for maximum participation and learning outcomes.
2. Training topics are to be cycled annually to ensure all staff receive refresher training.
3. Outlook management is to build competencies into award bands to encourage professional development.
4. As part of the transition from traditional Day Service delivery to a self directed approach, the following annual training topics are to be organised by Outlook One management.

Annual Training (internal and external)

A Self Directed Outlook: Practice Guidelines

- ⇒ Integrated into the induction process and linked with Outlook policies
- ⇒ Conducted with Team Leaders for disseminating learnings to their teams, including:
  - Assistance with Planning and Support Plans
  - Service Delivery Plan
  - Assessing Risk
  - Behaviours of Concern
  - Client Files and Case Noting Practice
  - Self Directed and Individualised Supports
  - Consumer Feedback
  - Community Capacity Building
  - Secondary Consultation
  - Professional development
  - Continuous Quality improvement.

Community Development Made Easy

Activity-based for applied learning, including:

- ⇒ What does community development and capacity building mean at Outlook?
- ⇒ Community ownership/participation (inclusiveness)
- ⇒ Attitudes (strengths based)
- ⇒ Opportunities and discovery
- ⇒ Active involvement in decision-making
- ⇒ The importance of networks.

Strengths Based Training

Session to include:

- ⇒ Refresh principles of approach
- ⇒ Conduct activities applying a strengths-based approach to personal, client and workplace scenarios (build skills in strengths-based assessment and planning).

Leadership

Basic training in concepts of:

- ⇒ Leadership and management – what's the difference?
- ⇒ Team dynamics
- ⇒ Communication
- ⇒ Time management
- ⇒ Administration.

Case Noting

- ⇒ Purpose
- ⇒ Principles
- ⇒ Good Practice
- ⇒ Recording, storage, transporting and disposal of client information in accordance with the health records and privacy legislation.

Decision making	**Driver training (Outlook vehicles)**
Innovation	**Manage behaviours and staff safely**
Problem solving	**First Aid**
Risk management / OH&S	**Medications**
Budgets	**Legislative, policy and service updates**
IT skills	**Continuous Quality Improvement**
Supervision	

Continuous Quality Improvement (CQI)

Definition

CQI: A management approach (style or method) to assessing and improving organisational systems (people, processes and tools).

Purpose

CQI is designed to improve the quality of systems or services and involves a process of self assessment or action research (Plan, Do Check Act). CQI should be embedded throughout the organisation at all levels in policy and practice, rather than a discrete system.

CQI is about constantly questioning our systems:

1. Are they as good as they can be?
2. How can they be improved?
3. How can we surpass expectations instead of just meeting them?

The Quality Framework (QF) for Disability Services refers to the importance of regularly monitoring and reviewing practice. The QF provides the following self assessment questions for consideration.

1. Do I use de-identified information from individual plans regarding participation goals, to inform the organisation's priorities and strategic direction?
2. Do I regularly monitor and review the participation of support users in the planning, development, monitoring and review of your service, and plan strategies to increase and enhance participation?
3. Do I implement staff learning, development and educational programs that address participative practice?
4. Do I regularly monitor and review the provision of information, and plan strategies to overcome structures and cultures that impede the provision of consistent, good information?
5. Do I implement staff learning, development and educational programs that address the preferred communication styles and provision of accessible information?
6. Do I promote and integrate into every day work, examples of good practice?

Procedures

1. All Outlook staff are expected on an ongoing basis to question and assess what they do, how they do it, and how it can be improved. CQI is a continuous journey that seeks to make our 'good', 'better'. Utilise the QF questions above as a basis for identifying your own areas of practice that need improvement, and opportunities for broader team and organisational systems improvements.
2. Outlook policy requires staff identifying areas for improvement to complete an *Opportunity For Improvement* (OFI) form. This is designed to record suggestions on how things can be improved; helps to keep track of improvements; and lets people know what is happening. OFI forms make the identification of incident trends easier for management and provide evidence of continual improvement to external auditors (for further information, please refer to the *OFI Form Procedure* on the Outlook Intranet site under 'Forms/Corporate/Quality/OFI). **Under no circumstances are staff to develop their own forms. If documentation is required or a system needs improvement, the OFI process must be undertaken.**

3. If you identify an opportunity for improvement within your own practice, the action cycle 'Plan, Do, Check, Act' is a useful tool for planning, trialling, evaluating and implementing change, new systems and/or new programs.

   Plan the change to be trialled; set objectives; determine the who, what, why, where, when and how; brainstorm solutions; set KPI's; plan

   Do a trial of the proposed change; collect data; document process and issues

   Check on the impact and results of the trial; analyse outcomes; determine suitability and effectiveness and capacity for broader implication

   Act on the results of the trial – if determined to be suitable, implement more broadly; if the trial is deemed unsuccessful, select another option to trial; identify the key learnings to inform this next PDCA cycle, and continue until the appropriate system/program is verified.

   (source: Quality Improvement and Community Services Accreditation website).

Appendix 1: Planning

The Act - Section 52

Definition:

Planning encompasses a range of responses from a brief discussion and agreement about actions required through to an extensive process and the development of a plan across a whole range of life areas documented in a format that is meaningful to the person and their network.

(1) Planning…should be undertaken to the extent to which it is reasonably practicable in accordance with the principles specified in sub-section 2.

(2) Planning should –

(a) be individualised

(b) be directed by the person with a disability

(c) where relevant, consider and respect the role of family and other persons who are significant in the life of the person with a disability

(d) where possible, strengthen and build capacity within families to support children with a disability

(e) consider the availability to the person with a disability of informal support and other support services generally available to any person in the community

(f) support communities to respond to the individual goals and needs of persons with a disability

(g) be underpinned by the right of the person with a disability to exercise control over their own life

(h) advance the inclusion and participation in the community of the person with a disability with the aim of achieving their individual aspirations

(i) maximize the choice and independence of the person with a disability

(j) facilitate tailored and flexible responses to the individual goals and needs of the person with a disability

(k) provide the context for the provision of disability services to the person with a disability and where appropriate coordinate the delivery of disability services where there are more than one disability service providers.

Appendix 2: Support Plans

The Act - Section 54

(1) This section applies if a person is receiving on-going disability services.

(2) If this section applies, the disability service provider must, in consultation with the person with a disability, ensure that a Support Plan identifying the disability services being provided to that person is prepared within 60 days of the person commencing to regularly access the disability services.

(3) While a person is receiving on-going disability services, a Support Plan —

  (a) may be reviewed at any time by the disability service provider or at the request of the person with a disability or a person on their behalf;

  (b) must be reviewed at least once during each period of three years commencing from when the Support Plan was first prepared.

(4) If a person ceases to receive on-going disability services, the Support Plan is terminated.

The Act - Section 55

(3) A person with an intellectual disability residing in a residential institution must have their Support Plan reviewed at intervals not exceeding 12 months.

Appendix 3: Further Information

www.dhs.vic.gov.au/disability

Day Services Guidelines 2011

Disability Act 2006

Individual Support Package Guidelines September 2010

Policy & Funding Plan 2010-2012

Access Policy

Access Policy Implementation Guide

Planning Policy

Planning Resource Kit & Implementation Guide

Quality Framework for Disability Services in Victoria

Register of disability service providers