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Topic 1

In this topic you will learn how to:

- 1A Identify and prioritise needs, goals and preferences**
- 1B Consult person and colleagues and co-ordinate services and support**
- 1C Outline and clarify service providers' roles and responsibilities**
- 1D Recognise signs of abuse or neglect and respond in line with organisational guidelines**

Coordinate the delivery of the individualised plan

In the role of a coordinator, you may need to evaluate the needs of older people with more than one condition, who require a range of support programs. The aim is to ensure older people's complex needs are identified and addressed individually. To do this, you must address, support and prioritise their needs using a range of tools and in consultation with a range of health professionals.

Here are considerations to make when prioritising needs.

Risk

Does the issue or need put the person at risk? For example, does the need:

- ▶ put them at risk of injury or harm
- ▶ prevent them from receiving nutrition or hydration
- ▶ put them at risk of illness or disease?

What is the immediate risk? For example, might the situation change immediately or next month? Issues or needs that put the person at risk are a higher priority.

Independence

Does the issue or need prevent the person from being independent? The following issues may affect the priority you give to dealing with a particular need. For example, is it likely that they will:

- ▶ need to move out of their own home into residential care
- ▶ need a higher level of care if they are in residential care
- ▶ put excessive demands for support on their family members, friends and carers?

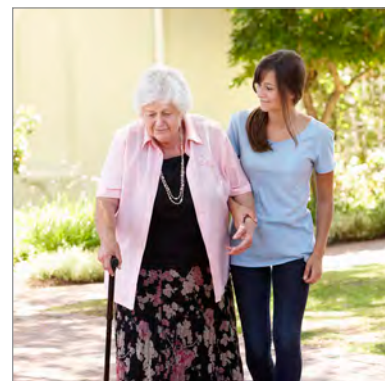
Participation

Does the issue or need prevent the person from interacting or participating in their community or social network? The following issues may receive a lower priority initially, but are still important needs for the person. For example, are they unable to:

- ▶ visit friends
- ▶ participate in their interests and hobbies
- ▶ get out in their community?

Complex care needs

Some older people you interact with will have a dual diagnosis or multiple diagnoses and hence they will have complex care needs. These terms have different meanings in different health care settings. In home support and general aged care environments, dual diagnosis means a person has been diagnosed with two distinct conditions and multiple diagnoses means they have been diagnosed with more than two distinct conditions. For example, an older person could have Parkinson's disease, chronic back pain and skin cancer.



In other fields, the definition may have a slightly different meaning. For example, in the mental health field, dual diagnosis or complex needs refers to a person with a mental illness and an addiction to drugs and alcohol. In the disability field, dual diagnosis refers to a person with an intellectual disability and a mental illness.

Preferences are closely related and often overlap with a person's goals and needs. Preferences may be physical, mental, emotional, spiritual or social. Preferences may relate to a person's cultural or ethnic background or their religious preferences.

Talk with the person about preferences detailed in the individualised care plan. If a person appears distressed or dissatisfied, it is possible their needs or preferences aren't being met. It is also possible that their needs and preferences need to be reviewed, or reprioritised because they have changed.

Here are some examples of needs and preferences.

Examples of needs and preferences

- ▶ A person is vegetarian. They only eat food that does not contain meat.
- ▶ A person is Islamic. They only eat food that is Halal, which means it has been prepared according to Halal specifications.
- ▶ A person is Islamic. They pray at five specific times of the day.
- ▶ A person prefers outdoor activities to indoor activities.
- ▶ A person has requested that they have the opportunity to go out dancing.
- ▶ A person likes to see their family every Sunday in a quiet, private location.

Duty of care, negligence and dignity of risk

When identifying and prioritising needs, preferences and goals, you have the responsibility to provide a duty of care to ensure the safety and wellbeing of the person. Legislative and regulatory obligations underpin an organisation's policies, which determine the procedures to guide service delivery that promotes and enhances the safety and wellbeing of people.

Here is more information about duty of care, negligence and dignity of risk.

Duty of care

- ▶ Duty of care is the obligation a person has to act in a way that would not cause harm. You have a moral and legal obligation to ensure you do all that is possible to ensure the person's safety.

Negligence

- ▶ Negligence occurs when duty of care has been breached and harm to either person or property ensues. It is the legal and ethical obligation of any community worker, supervisor or organisation to ensure that people using services are not exposed to unnecessary or unreasonable risk.

1B Consult person and colleagues and co-ordinate services and support

Providing services to older people should be done in collaboration with the person, and with others providing support. The person should be integral to all decisions made.

Consultation may be done in person, through letters or email or over the phone. Consultation should be open, clear and specific. Adjust your communication style to meet the person's needs. For instance, if the person has language needs, you may need to speak slower and more clearly. You could also engage visual material.



Interview to gather information

When gathering information about the issues affecting an older person, sit and talk with them and, where possible, their close family members or carers. If a face-to-face discussion is not possible, a telephone interview is a useful solution.

Some people find assessment stressful. Be courteous, speak clearly and use appropriate interpersonal skills, such as empathy, body language and active listening, to show interest in the person and establish a positive atmosphere. A carer, advocate or family member may need to be present if the person has communication difficulties. Here are points to note about interviewing.

Conducting interviews

- ▶ Interviewing is different to just having a conversation as it involves asking a person a series of questions to obtain specific information.
- ▶ When interviewing a person, they will feel more comfortable if the tone is conversational.
- ▶ When conducting the interview, you need to know the type of information required from the person and their family members.
- ▶ Most services have a form to complete for gathering information about the person and their needs.
- ▶ The interview will flow more naturally if you can become familiar with what you want to learn about the person.
- ▶ Try not to look at the form too much while talking but take notes as you talk so you record all the required details.
- ▶ Ask questions in a way that steers the conversation or gathers extra information without making the interview feel formal and rigid.
- ▶ The information collected is likely to be more detailed and comprehensive if the person and their family members or carers are relaxed.

When to seek assessments

There are situations that require expertise that you do not have. The person's situation will determine the number and types of professionals that need to be involved with assessing and prioritising support needs.

You may need to seek assessment when:

- ▶ a person has multiple conditions that you believe requires a high-level assessment
- ▶ you may need to know more about a person's needs
- ▶ you may need to find out which needs are higher-priority
- ▶ a person's condition may have worsened and their original diagnosis and assessment are no longer current
- ▶ a person's family may insist that further high-level assessments are carried out.

Collaborate with others

Here are some ways you can collaborate with others, including your supervisor, your colleagues and health professionals.

Liaise

You may meet with all the professionals and workers involved in the assessment in a single meeting, known as a case meeting or case conference. Alternatively, you may need to meet or talk to each of the professionals individually. Be prepared with appropriate documentation about the person and any questions you need to ask.

Ask, clarify, seek feedback

You may need to ask a specific question about the older person's well-being to clarify your understanding. Together, you and the professional will be able to decide whether a high-level assessment is required.

Always seek feedback if you are unsure whether a person needs further assessment. It is better to be rigorous in your job than be uncertain about a course of action that may have serious consequences.

Document issues

Make sure you document the issues raised, the people who have contributed the information and the action to be taken. List the different assessments that the professionals and supervisors decide need to be carried out.

Negotiation

You may need to negotiate with a health professional to ensure that a high-level assessment is carried out. If you provide them with sufficient background information, they may agree that further assessment is needed.

You may need to negotiate with your supervisors and colleagues to ensure that the person's needs are being met fully.

Provide information and reports

Make sure you collect any initial assessments, progress reports or other documents that may help others decide whether more support is required.

Seek advice from appropriate personnel to determine service issues

You may need to consult with others to determine how the service is delivered and whether there are any issues that need to be resolved. If so, you need to identify with the relevant people what needs to be done before the service can be delivered. It may be that your service cannot provide the specific support that is required for the person because of their multiple conditions and you have to refer the person elsewhere.

Consider whether the person will need:

- ▶ a number of support workers rostered throughout the day
- ▶ transport
- ▶ personal care help
- ▶ help to maintain their home
- ▶ mobility aids
- ▶ social activities that meet their cultural needs as well as their diagnosis.

Ongoing consultation

Ongoing consultation with the person and their significant others is required to ensure they are kept informed about the progress of assessment, evaluation and prioritising. You need to make sure the care plan continues to meet their needs and expectations and continually check the currency and accuracy of the information. The consultation process allows you to take the person's support needs into account when interpreting information and identifying and prioritising complex care needs.



Care plans

Care plans contain information about the person's health, mobility, eating preferences, religion, traditions, and likes and dislikes. They may also contain information about medication, managing the client's pain and any behavioural and safety issues you need to be aware of.

You should report any changes that you notice in your client's mental or physical state that differ from the information in the care plan.



1C Outline and clarify service providers' roles and responsibilities

Once an individualised service plan has been produced, the focus shifts to implementing the plan. A significant part of coordinating the delivery of services described in the service delivery plan is making very sure that everybody involved in the service delivery is clear about their role and their responsibilities. The commencement and continuation of service delivery to the person must be co-ordinated as the delivery of services might involve a number of different service providers. Each service provider must know how to contact the co-ordinator if they do not understand the plan, cannot fulfil their responsibilities or notice a change that must be reported.

You need to communicate regularly with those providing the services, making sure they have all the information and resources they require to meet the goals set out in the plan. It is especially important to provide support to workers, the older person and their carer, both in the initial stages and as an ongoing feature of service delivery.



Delegate services and care activities to relevant workers

As the coordinator, you need to delegate different parts of the service delivery plan to the appropriate workers; that is, those with the right skills to deliver the service. To delegate effectively, you need to identify the type of skills or activities required, and then identify the appropriate type of worker or service provider. In some cases, this may be a worker or health specialist within your service. At other times, you may need to refer the delivery or service to another provider or purchase the service from another provider. The way you delegate depends on the service you work for. Here are some examples of services that may be required and the relevant service provider you may need to coordinate.

Meal preparation

- ▶ To develop a person's knowledge of cooking and preparation of meals for diabetics, you may need to arrange for Meals on Wheels or a home support worker.

Behaviours of concern

- ▶ If you need to address behaviours of concern, a diversional therapist may be engaged to develop and implement appropriate diversional activities for those exhibiting behaviours of concern.

Daily personal care

- ▶ For an older person who requires daily personal care assistance, you will need to coordinate the services to ensure they are provided by a suitably qualified aged care worker.

1D Recognise signs of abuse or neglect and respond in line with organisational guidelines

Abuse is a complex issue. It can be financial, physical, emotional, sexual or failure to provide adequate care for a person's basic physical, social and emotional needs. A person experiencing abuse may show signs of physical or mental anguish or may demonstrate more subtle signs of abuse such as withdrawal and anxiety.

You have a duty of care to the people you are supporting to keep them safe and free from harm. Your duty of care is increased in instances where people are more vulnerable to harm from others due to age or impairment. It is useful to know the factors that may contribute to a person being at risk of abuse or neglect.



Risk factors

Certain risk factors make a person more vulnerable to abuse or neglect.

People at risk are those who:

- ▶ have a cognitive impairment; for example, dementia
- ▶ live alone
- ▶ have a history of family abuse
- ▶ misuse alcohol and other drugs
- ▶ are stressed or are emotionally unstable
- ▶ have financial issues
- ▶ are relatively powerless; for example, children and older people.

Causes of abuse

Abuse can be intentional or unintentional. Intentional abuse is when a person deliberately causes harm to the other person by depriving and/or hurting the other person. Unintentional abuse can occur when another person doesn't realise, through ignorance or other reasons, that their behaviour towards the person with care needs is abusive. An example would be when a primary carer hasn't had a break and is caring for someone with very high needs. If there is no one else the carer can call on, they can become very tired and resentful; not realising the impact their behaviour is having. This is still abuse and needs to be reported.

Identify abuse and neglect

You and your team will only detect abuse if everyone is aware about abuse and understand how to respond to situations of abuse. This is particularly important when the older person is unable to make decisions regarding their own wellbeing; for example, if they have a form of dementia. Sometimes abuse is obvious and easy to detect, while at other times it may be quite subtle and difficult to prove. Sometimes it occurs when a worker has a momentary lapse of judgment; for example, fails to respect an individual's privacy and dignity or isolates them socially and emotionally.



Signs of abuse and neglect

Make sure you and your team members are familiar with the signs of abuse and neglect. Changes in behaviour can be a result of other things as well as being an indicator of abuse, so it is important to check your assumptions before coming to the conclusion that the person is in fact being abused.

Here are some indicators of abuse.

Behaviour changes of person with care needs

- ▶ A person may become withdrawn, depressed, and anxious or display signs of being scared. They become quite ambivalent or non-responsive.
- ▶ You might find the person is becoming disorientated or making contradictory statements. (This of course can be a sign of a range of illnesses, so should be thoroughly assessed before making an assumption that the person is being abused.)

Behavioural signs from the carer

- ▶ You might encounter situations where the carer makes lots of excuses so you cannot gain access to the person with care needs.
- ▶ The carer might be overly affectionate and flirtatious with the person which might indicate an inappropriate sexual relationship.
- ▶ You might find the carer is giving conflicting accounts of incidents or is hostile towards the person with care needs.

General indicators

- ▶ Changes in the person's health such as unexplained weight loss, bed sores, poor colouration, sunken eyes and cheeks.
- ▶ Unexplained injuries or continual injuries.
- ▶ Person's personal care needs not being met which can be indicated by dirty hair, dirty clothing, soiled bedding and unclean living conditions.
- ▶ Inappropriate use of medication, such as drugging the person so they sleep for longer periods of the day and night.

Immediate reporting required

Situations that require immediate reporting in accordance with an organisation's guidelines:

- ▶ You observe someone behaving towards a person in a way that makes you feel uncomfortable.
- ▶ A person shows a sustained change in behaviour or mood.
- ▶ A person tells you they are being abused or harmed by another person.
- ▶ A person, staff member or visitor tells you they have observed abusive acts.
- ▶ You observe an action or inaction that may be considered abusive.
- ▶ Someone is not responding to the financial or medical needs of a person.
- ▶ You have clear evidence an abusive situation is occurring.

Report processes

To report abuse you must follow your organisation's procedures, and all staff need to be aware of the compulsory reporting requirements for allegations or suspicions about abuse. Report and respond only to those signs for which you have witnesses or evidence. Look for signs that show that this is what has really occurred. Remember that this can be difficult when the person has memory problems or is confused, but do not disregard this information or assume concerns are just a result of their condition.

Here is what service providers must do to report instances of abuse. It may be your role to carry out some of these tasks.

Make reports

- ▶ Report abuse to the relevant people, such as your supervisor or senior manager who may be required to report the matter to the relevant agency in your state or territory.
- ▶ Report the situation, when advised by your manager, to the Commonwealth Aged Care Advocacy Service, the Aged Care Complaints Investigation Scheme, the State Guardianship and Administration Board, or the ombudsman.

Document details

- ▶ You may speak to your manager or supervisor verbally, but you must also document the report. Provide details in progress notes or case notes and fill out an incident report form with what you saw (the signs), when you saw it, what you did, the older person's response and follow-up action taken.

Discuss with the older person

- ▶ Provide people you are supporting with an opportunity to talk about what is happening with them and inform them about services to assist them. You may be the only person available for some people to speak to; you may need to prompt discussion by gently raising your concerns with them.

Summary

1. Learn to recognise an older person's needs, goals and preferences. These will correspond with their individualised care plan. Know how to prioritise needs, goals and preferences, particularly if there are complex needs.
2. The social model of disability should underpin the care you provide. This is also a person-centred approach.
3. Assessment can be used to identify needs. Assessment often requires the input and advice of a health professional. In some cases, a high-level assessment is required.
4. In addition to the advice of health professionals, different assessment methods, tools and sources can be used to provide a picture of the older person's needs. Be aware of the limitations of your role and expertise.
5. Consult health professionals, your colleagues and the person being supported to obtain an integrated perspective on the person's needs and the support that needs to be provided.
6. Coordinate the service delivery by ensuring that all staff members are aware of their roles and responsibilities.
7. Be aware of the different types of abuse (physical, emotional, financial, neglect) and the signs to watch for. Follow workplace procedures to report any signs of abuse immediately to prevent further abuse from occurring and/or the abuse escalating.

Consider the following when supporting a person to access resources.

Considerations when accessing resources

What is the cost of the resource, and can the person afford this cost?

Are there any specific communication needs, such as translation, and how will you meet these needs?

Where is this resource located? Can the older person access this location?

How will this resource impact the person?

Will this resource meet the older person's needs?

Support the older person to negotiate resources

Support the older person to access and negotiate resources. Negotiation may be required if, for example, there is a cost issue. The person may not have the funding to access the resource, and so needs to negotiate how to pay. This may require you accessing further resources; in this case, financial aid or advice.

Due to communication barriers, the older person may not be able to negotiate the resource themselves. The provider or the resource may take advantage of the older person. Support the older person to negotiate their rights, and ensure they have the means to communicate.



Example

Access and negotiate resources

The financial circumstances and goals of a person need to be considered when supporting them to access and negotiate resources.

Mrs Mahoney

Mrs Mahoney is on an aged pension. She owns her unit but has no other income or assets. She has been assessed and one goal of her service delivery plan is to move into residential care. Mrs Mahoney's financial situation must be considered when deciding which type of residential facility is suitable. She needs to avoid paying a large regular fee. She is more likely to be able to manage the cost of a facility that requires a large up-front payment (which she could pay from the sale of her unit) and then charges only a percentage of the pension as a regular fee.

Harry

Juan has assessed Harry and identified that he is unable to shower independently, as he is quite shaky and often feels off-balance. A goal of Harry's service delivery plan is to make sure he is showered three times a week. Juan looks at the option of having a worker attend the house three times a week to help Harry. Juan also considers providing Harry with a shower chair and having grab rails put in the shower and bathroom, which means Harry could sit during his shower and have rails to hold when getting in and out. The second option provides Harry with more independence and is less costly.



Centre-based respite

Day respite; residential day respite and community access group respite.



Cottage respite

Overnight community-based respite.

Assistance with care and housing

The target group for this program are people aged 50 years and over who are on low income and either homeless or at risk of homelessness. The program assists people through:

- ▶ providing streamlined access to support services
- ▶ standardised assessment processes
- ▶ focus on restorative approach
- ▶ promoting equity and sustainability
- ▶ reducing red tape for service providers.



You can read more about the Commonwealth Home Support Programme and assistance with care and housing at the following site:

- ▶ www.dss.gov.au/ageing-and-aged-care/programs-services/commonwealth-home-support-programme

Example

Support access to community support services

Susan has developed a service delivery plan to address the needs of Mrs Jenny O'Neill who wishes to remain in her current living situation. Mrs O'Neill is cared for by her daughter, Philippa, in Philippa's family home.

As part of the plan, Philippa's need to have regular respite is to be addressed by referral to the local planned activity group, which is part of a home and community care program run through a regional provider.

An additional respite goal is for Mrs O'Neill to stay in an aged care home for two weeks, three to four times a year so Philippa can have a longer break.

In order to access residential respite in a funded aged care home, Mrs O'Neill must be assessed as eligible by the aged care assessment team. Susan calls the local Aged Care Assessment Team (ACAT) to make a referral for Mrs O'Neill to be assessed.



Below is a list of possible actions you could take if you observe that the service is not providing adequate support.

Actions to take if a service does not provide adequate support

- ▶ Consult with your supervisor, person's family, carer or advocate and relevant professionals, such as the doctor, psychiatrist or physiotherapist.
- ▶ Consult the older person about changes that have occurred, and changes that need to be made.
- ▶ Clarify the issue and cause of issue.
- ▶ Identify options for making changes.
- ▶ Discuss how changes can be made with minimal disruption to service.
- ▶ Review the individualised goals in the support plan.
- ▶ Review the individualised support plan.
- ▶ Consult the older person and team about making the changes.

Example

Identify inadequacies in the service and take action

Assessment information about Mrs Hemmerling was gathered at an interview with her and her son before she moved into an aged care home. At assessment, Mrs Hemmerling indicated that as long as there was a shower chair available, she could shower independently. The resulting service delivery plan indicated that the shower chair was required.

Since moving into the care home, Mrs Hemmerling has slipped in the shower twice and pressed her emergency call bell frequently because she has felt nervous and unstable.

The coordinator, Anja, re-assesses Mrs Hemmerling's needs and finds that a shower chair is not enough to meet her needs. The service delivery plan is amended to indicate the need for a worker to assist Mrs Hemmerling with showering each morning.



Practice task 7

1. Think of three reasons why the service delivery plan may not be providing the right level of service.

Here are some places and people you may refer to.

Refer carer

You may refer the carer to:

- ▶ a GP for physical, mental or emotional support
- ▶ a counsellor for emotional support
- ▶ financial counsellor for financial support
- ▶ employment agency for advice about how employment can work around care
- ▶ respite agencies
- ▶ housework agencies
- ▶ food delivery services.

Refer person you are supporting

To provide additional support to the carer, the person being supported may require additional support. You may make a referral to:

- ▶ a GP for medical advice
- ▶ a counsellor for emotional support
- ▶ community support agencies.

Example

Recognise the impact of support issues on the carer/s and families and refer appropriately

Linda is the primary carer for her mother Holly. Holly is 91, and has Alzheimer's. Linda is married with three children and works part time. She used to work full time, but when her mother's needs increased, Linda cut back to look after her mother.

Linda visits her mother daily. She helps dress her, and prepare her meals for the day. She helps Holly with her daily schedule, and reminds her of any appointments or activities she has planned. If Holly has a doctor's appointment, Linda accompanies her to the clinic.

Holly hasn't got many friends anymore. She is often lonely and relies heavily on Linda both physically and emotionally. After several years of caring for her mother, Linda starts to experience exhaustion and signs of depression. She has little time for her own family, or interests. She sometimes feels resentful towards her mother, but does not complain, as she regards it as her duty to provide support.

Tamara, Holly's case worker, notices that Linda is struggling. She calls Linda in for a chat, and suggests that she might need some time out to look after her own needs. Tamara suggests putting Linda in touch with a respite service that may be able to address Holly's needs some of the time, so Linda can have a break.



Example

Provide support and respite for carer/s

Kate is a consultant who works with respite service providers to assist them to improve and grow the services they offer to primary carers. She often trains workers in carer-friendly practices to highlight the burden of caring, the needs of carers and the impact carers have in the community and on the economy. Kate says:

‘Many carers have difficulty identifying with the term ‘carer’. They feel that as a husband, wife, son or daughter or even friend, caring for their loved one is just what you do. It can help to explain that the term carer is one that is recognised in politics and in the area of community-care funding. Often carers don’t think to ask for help for themselves.

Many carers never expected that there would be services specifically designed to support them. It is sometimes really valuable to get carers together as a group. Often a carer will hear or understand information much better if it comes from another carer. I guess a carer can put the information in context for them and show them the benefits.’



Practice task 9

Read the case study, then answer the questions that follow.

Case study

Tony is 69 years old and cares for his wife, Lena, who was diagnosed with Alzheimer’s disease seven years ago. Tony gave up his full time job as he could no longer leave Lena alone in the house for even half a day.

Lena has developed behaviours of concern such as breaking household items and yelling. She thinks she can still do things like drive the car, go for a walk or boil the kettle. She must be supervised at all times. She doesn’t sleep through the night and wakes Tony in the early hours of the morning.

Without regular respite, Tony knows he would not be able to care for Lena at home. Lena has been assessed for services by the local home and community care agency and the carer respite service. She goes to a day centre group for women with forms of dementia two days a week. Lena has three stays per year in a secure aged care home. Each stay is two to three weeks long and Tony likes to plan to go away himself for one or two weeks each time.

Tony has help from the home and community care service with cleaning and a worker comes to the house for three hours a week so he can do his shopping. He also knows that if something unexpected occurs, such as getting sick himself or having a special event to attend, he can call on the carer respite centre for additional in-home respite. With all this support, Tony knows Lena can stay at home for a few more years.

1. Identify direct respite care services that Tony receives.

4A Explain mechanism/s for providing feedback on the individualised plan

An individualised service delivery plan must be regularly monitored, evaluated and reviewed. This ensures the plan continues to meet the complex care needs of the older person. You need to identify whether the service is being delivered correctly and make adjustments where necessary. You can use case notes, observation and feedback to monitor and evaluate the service delivery plan. These are all feedback mechanisms.



Although each service delivery plan should be formally evaluated and reviewed at least once a year, an immediate re-evaluation and review of the plan should be conducted where feedback is received indicating the service is not meeting the person's needs. It could be that a need does not have such a high priority anymore, that the person's condition has worsened or that other conditions have developed.

Provide feedback

Coordinators must actively seek feedback about the progress of the service delivery plan. Any changes or issues noticed should be documented and a response made to ensure the services delivered will meet the older person's care needs, and the older person's health and safety is not at risk. An inappropriate level of care may mean the older person's quality of life decreases.

Feedback from service providers is valuable as they see the older person frequently and, if they are specialists, they can provide feedback on specific health issues. When the service delivery plan is prepared, all service providers should know how to provide feedback about the progress of the services they provide.

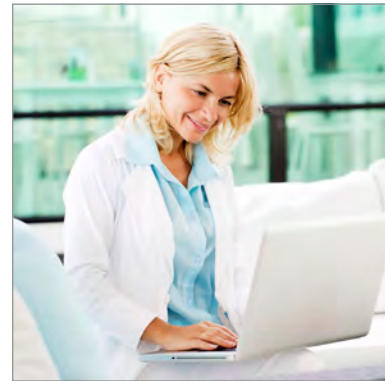
Service providers need to know:

- ▶ who should receive the feedback; for example, the coordinator of the program
- ▶ when they need to provide feedback; whether weekly, monthly, six-monthly, immediately as an issue arises or when care needs change
- ▶ the type of feedback required, which may comprise observations of changes in behaviour, condition, effectiveness of service and so on
- ▶ how the feedback is to be delivered; for example, by telephone, in person, at case conferences, or through written progress, case notes or incident reports.

Technology and digital literacy

Most care and support staff that are providing support and care services now need to be computer literate to write and save records required for monitoring the care and support of a person on the computer system of a facility or organisation.

There is an inbuilt mechanism for supporting the use of objective language in aged care reporting, where programs offer a drop down menu of phrases that can be used to describe changes in a person's state and care needs. The use of digital technology allows all records needed to provide an accurate picture of a person's condition and needs to be located together.



Appropriate and inappropriate feedback

If you read the following in a person's progress notes, you would be unable to form a clear understanding of changes in Mrs Bradshaw's health and care needs:

'Provided assistance to Mrs Bradshaw today with showering and dressing. She seemed a bit wobbly today. She sometimes seems like this.'

A co-ordinator would find it hard to assess what actions may be required.

The following report is written in objective language and includes appropriate details.

Progress notes for Mrs Bradshaw

Provided assistance to Mrs Bradshaw today. When she was in the shower, she complained of feeling dizzy. I assisted her out of the shower and with drying and dressing. While doing this I asked her for more information. She said she had felt dizzy a couple of times over the past few weeks. She said her doctor had discovered two days ago that her blood pressure is quite low. She says her doctor has prescribed medication and advised her not to stand up for long periods.

Analysis of notes

The nature and frequency of, and possible reasons for the issue are explained. The coordinator reading this report knows that possible appropriate actions could be to contact the doctor for further information and to arrange for a shower chair.

Provide verbal feedback

Encourage service providers to provide feedback verbally via the following methods.

Over the telephone or face to face

- ▶ A service provider may phone to provide feedback if it is important that the feedback is received quickly. Where the service provider is a staff member at your own agency or if they are with the older person when you are there, feedback can be provided face to face.

Responding to feedback

- ▶ When you receive feedback from the older person or their advocate, you need to follow up. Investigate any concerns by asking service providers to clarify any changed care needs, reassess needs or request health professionals to provide an assessment of a particular area of need. It is important to tell the person or their advocate what will happen with the feedback provided. Make sure they are clear about what to expect and when.

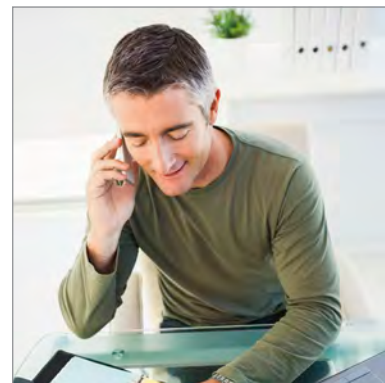
Report to supervising health professional

You need to relay information you obtain from the older person or their advocate to the supervising health professional. This may be a registered nurse, a doctor or another medical professional.

The health professional needs to be briefed about any changes in the person's status, so that adjustments can be made to their service delivery plan as quickly as possible.

Reports can be made verbally, over the phone or face-to-face, such as in a case meeting. Written reports, such as letters, must comply with organisational policies.

Always be accurate, object and succinct. Relay the older person's feedback exactly as they presented it. Remain as impartial as possible.



Example

Seek feedback from the older person and report to supervising health professional

Mrs Steiner phones Larry, the coordinator of the local home support service. This service provides Mrs Steiner with personal care services three days a week and cleaning once a fortnight. Larry did the original assessment and service delivery plan development for Mrs Steiner. Mrs Steiner tells Larry she would like a few changes to her service delivery plan.

Mrs Steiner explains that she has just given up her driver's licence and can no longer drive to the shops. She would like help to do a full supermarket shop once a fortnight.

She has also noticed the very high windows in her sunroom are dirty and wonders if the home support worker could clean them.

After considering the feedback:

- ▶ Larry tells her he will arrange for the home support worker to stay an extra one and a half hours each fortnight to drive Mrs Steiner to do her supermarket shopping.
- ▶ Larry provides her with phone numbers of private contractors who clean windows as the home support worker is not permitted to climb a ladder to clean high windows.
- ▶ Larry makes a note of all Mrs Steiner's changes.
- ▶ Larry files a report to the registered nurse, who supervises the support service. The RN reviews the changes, and is satisfied that no adjustments need to be made to Mrs Steiner's health plan.