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Demonstrating professionalism

- ▶ Make sure you look the part – if your clothes are untidy or dirty, it is possible people will see you as being untrustworthy. A clean and tidy appearance suggests that you care about your job and, as an extension of this, the person and their needs.
- ▶ Maintain and develop your skills and expertise, so you can respond appropriately to people.
- ▶ Be competent – perform all duties to the required standard. It can be worthwhile seeking feedback from your manager and others to check you are meeting standards.
- ▶ Follow up on all promises – don't make promises you are unable to keep or that fall outside of your scope of practice or level of responsibility.

Demonstrating respect

- ▶ Have a positive regard for the person – your actions reflect your feelings. If you have a genuine interest in the person's wellbeing, it is reflected in your actions.
- ▶ Have empathy – imagine how you would feel if you were in the person's position.
- ▶ Be open – understand that the person's point of view might be different from yours.
- ▶ Do not just tell the person you are interested in helping them, show them by allowing the time needed to discuss their concerns, preferences, wishes, needs and goals. Attend to what they are saying.

Using active listening

- ▶ Use active listening to show the person you are interested in what they have to say.
- ▶ Briefly recap what the person has said in your own words.
- ▶ Soften your summary with phrases like:
 - 'You feel ...'
 - 'It sounds like you ...'
 - 'You think ...'
- ▶ Use paraphrasing statements more than questions.
- ▶ Allow plenty of time and pauses for the speaker to add to what they are saying.
- ▶ Focus on the last or the most prominent feeling, if more than one feeling is expressed.
- ▶ Do not add to or subtract from what the speaker has said.
- ▶ Use neutral words, body language and tone of voice.

1C Recognise and respect diverse and multifaceted needs of the individual and collaborate with others

Often people accessing community services are facing complex situations. People accessing an organisation will come from a variety of backgrounds and will accordingly have diverse needs. These needs may relate to their personalities, their cultural backgrounds, their life experiences and the skills or level of support they have within their families and the community. For example, two people with the same mental health diagnosis may access the same organisation. One person may require support to access accommodation and health care. The other person may require support to return to education or employment. Individual needs are rarely simple, and often have many different aspects or sides to them.

These diverse and multifaceted needs may require you to collaborate with other service providers to ensure the person's needs are met.



Diverse needs of individuals

People requiring support from community service organisations are as diverse as the general population is. They come from different cultural and socioeconomic backgrounds, are different ages and genders, and have varying levels of support from their families, friends and the wider community. This means that the needs of these individuals are also diverse.

You will need to acknowledge and understand the diverse needs of the people you support, and respect the varying backgrounds that underlie these needs. You will also need a range of strategies to identify and meet the needs of individuals, which could include some of the ideas below.

Strategies to support diverse individuals

- ▶ Use interpreters
- ▶ Use translated materials
- ▶ Use pictures and photographs
- ▶ Be aware of your own biases and prejudices
- ▶ Recognise diverse needs and individual abilities and language
- ▶ Treat people fairly and acknowledge differences
- ▶ Respect differences
- ▶ Use appropriate verbal and non-verbal communication

1D Provide accurate information about service delivery and support the interests, rights and decision-making of the person

Most people pursue careers in community services because they have a genuine interest in helping others. Despite this, some workers can impact negatively on a person by developing goals and strategies on behalf of the person, rather than in conjunction with them. This can make a person feel as if their opinion is worthless and their wants and needs unimportant. People who feel like they have control over their own lives (self-determination) are more likely to experience positive mental health than those who feel that they have little power in making decisions or doing what they enjoy. For this reason, it is important to support a person's interests, rights and decision-making. One way to support self-determination for a person is to provide them with clear, accurate and current information about the services your organisation provides.



Information about service delivery

In order to work collaboratively with a person, and to ensure that they are able to make the best choices for themselves and their care, it is important to provide them with clear, accurate information. The person needs information on the types of services provided that they are eligible for, how much these services will cost, where the services will be provided (in their home, at the organisation's office, or elsewhere), how many hours of service they can receive and the time frame for the service, and who will provide the service.

If the person requiring support either does not receive this information or does not understand the information there are consequences for them. They may feel unheard or disempowered, refuse services they need, or may accept services they do not want. They may become frustrated or angry because the services they receive are not what they expected or wanted. For this reason information must be presented in clear language (with the use of translators if required), and must be accurate and current.

Support the person's interests

An individual plan should be person-driven. This means the person should determine the goals and the activities contained in the plan. In some cases workers may feel they have greater insight into a person's needs than the person themselves. However, it is important to discuss this with the person and ensure the final plan reflects the person's own interests, goals and preferences. A person is more likely to meet their responsibilities, as listed in the individual plan, if they have been involved in determining what their responsibilities are.

Psychological factors

Life stage psychological factors can have a significant influence on service delivery. The person's perspective on their life and events in it can be impacted by their psychological development and maturity. For example, an adolescent who is at a stage where they are self-aware and easily embarrassed may be focused on privacy, and uncomfortable with any service delivery that 'invades' this privacy. An elderly person who has experienced significant loss, may not be able to fully participate in services due to grief.

Example

Determine the physical and psychological factors relevant to the person's life stage that will influence service delivery

Bob is 52 years old and has been unwell in a psychiatric ward for almost five months. Before he became unwell, Bob had a managerial position with a major bank and lived at home with his partner and their two children. Since his illness, Bob has been made redundant from his position.

Bob feels like the most important thing for a man his age is to provide for his family. Bob's sense of self and confidence came from being successful in business. While Bob recognises that there are other aspects of his life that he needs support in, his focus is on returning to the workforce.

When planning for service delivery with Bob, the support worker will need to consider that at Bob's life stage employment is an important role and will need to be considered with service delivery.



Practice task 5

Read the case study, then complete the task that follows.

Case study

Frederick is 76 years old and you have recently been asked to prepare an individualised plan with him. Frederick lives in his own home, but recently, after some significant complications due to diabetes, he has had to move to supported accommodation. Since the complications, Frederick uses a wheelchair and is no longer able to play golf, which he has done for many years.

1. What are the physical factors of Frederick's life stage that may influence service delivery?

2. What are two psychological factors of Frederick's life stage that may influence service delivery?

Explain the purpose of the planning process

The community services sector, including aged care, disability, mental health and more, are all regulated. This means that documentation is necessary to make sure all actions can be tracked, monitored and reviewed, as required. A person may find the whole process overwhelming. They may not understand why you need to ask them so many questions, or why you write down their answers. They may also be unaware of the level of planning required when developing the individualised care plan and related documentation.

The person may feel disempowered by the process and become uncooperative in an attempt to regain control. They are more likely to cooperate with you, other coordinators and workers if they understand how the process can help them achieve their goals. This empowers them with a sense of control that is important for all people.

Discuss different service options

You will need to discuss the different service options available to the person. It is important that you are aware of the service options available at your organisation and that you are able to clearly outline these to the person. Remember to check that they understand each of the options available and the costs and benefits of each. Below is an example of some service options, and the features of each.

Service options



Attendant care and support work services

Attendant care services help the person do everyday tasks like personal care, domestic tasks, home nursing, community engagement and implementing rehabilitation plans.



Recreation, leisure, community access

Recreation, leisure and community access services support the person to access and participate in recreation and leisure activities like sport, art, music or community groups.



Community nursing services

Provide professional nursing services to the person in their own homes.

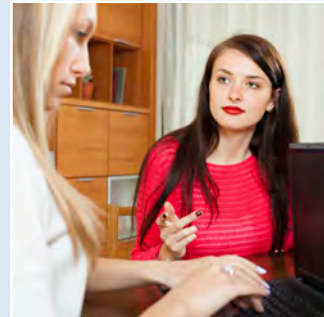
Select most appropriate service option

As part of the process of delivering person-centred care, you must make sure you choose the planning options that best meet the person's needs. Discussing different planning options with the person will have presented them with options, and the advantages and disadvantages of each approach. Each person is an individual with their own likes, dislikes, experiences and background, so what works for one person may not work for another. Some people prefer a more conversational approach to a formal, documented process. It is important to discuss the most appropriate option with the person to identify their particular circumstances and preferences. This needs to take into consideration their resources, such as financial resources and the support of family, friends and the community. It should also consider physical and psychological factors, the specific situation, needs and their ability to access services.

Example

Work with the person to determine readiness for the development of an individualised plan

Yvonne is working with Rita to assess her readiness to develop an individualised plan. Rita has been diagnosed with depression, but has been in recovery now for eight months. She is able to understand the planning process and make decisions regarding service provision. Rita feels comfortable working with Yvonne, as they are about the same age and have similar backgrounds. She feels confident that she can express herself and her needs to Yvonne. Yvonne explains the range of services available, and then Rita and Yvonne discuss which service will best meet Rita's identified goal to gain employment.



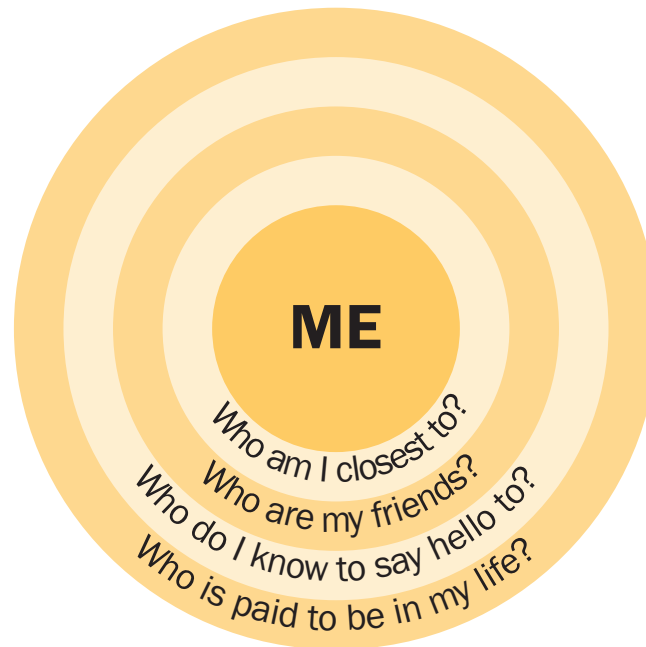
Practice task 7

1. Explain your understanding of what an individualised plan is.

2. What are the strategies you can use when working with and supporting a person?

Prepare a relationship map

Another visual tool for identifying stakeholders is a relationship map. Both genograms and relationship maps can be created by the worker and person together. This can be a useful way to develop trust, as well as discussing the person's support networks in a non-threatening environment. A relationship map helps you and the person to identify their support network, as well as the various types of relationships they have and maintain. Here is an example of a blank relationship map that can be completed.



Include others in the planning process

Depending on the person's circumstances, it is important to involve significant stakeholders in the planning process. The people who might be included are the person's assessor, their carers and support workers, health professionals, and other service providers/workers who are involved with the person. It is also important to include other significant people in the person's life, such as family members, friends, neighbours, or community and religious leaders.

You will also need to decide with the person how each of these stakeholders will be involved in the planning process, and what their roles and responsibilities will be. These roles can include providing written information, participating actively in the planning, or simply being available for support during the process.

Functional ability forms

- ▶ Functional ability assessment form assess a person's ability to carry out activities of daily living, such as ambulating, transfer, continence, bathing and showering, grooming and dressing. Examples include the Bartel Index and Katz Index of activities of daily living.

Health assessment questionnaire

- ▶ The health assessment questionnaire builds on the medical information contained in the person's personal information form. It allows the person to self-assess the health and wellbeing of all of the body's systems including:
 - respiratory
 - integumentary
 - cardiovascular
 - gastrointestinal
 - urinary
 - genito-reproductive
 - endocrine
 - central nervous.
- ▶ These forms are written in plain language, making it easier for non-health professionals to understand the questions.

Psychosocial need forms

- ▶ Psychosocial need forms allow people to self-assess the quantity and the quality of interactions with others.

Mental health forms

- ▶ Mental health and wellbeing forms ask the person to disclose their sense of satisfaction, their energy levels, fear, general outlook, optimism or pessimism and their engagement in daily activities. Answers to these questions can signal serious mental illness such as depression.

Mental status exam

- ▶ Mental status examinations are used to assess the older person's cognitive ability (their ability to think). Cognition includes short- and long-term memory, intellectual ability, attention and reasoning.

Practice task 9

1. Why are templates useful in preparing for planning?

2. What are four ways you can distribute information to stakeholders prior to the planning session?

Summary

1. Explore the physical and psychological factors related to the person's life stage that will influence service delivery.
2. Explain why the planning process is important to the person and discuss service delivery options.
3. Alongside the person, assess their readiness for an individualised plan.
4. Find out who needs to be involved in the planning process and what their roles will be.
5. Organise any practicalities regarding the planning process.
6. Gather and prepare information for the planning process and distribute to relevant stakeholders.

Strengths-based approach

A strengths-based approach is a way of working that recognises the resilience of individuals and focuses on their abilities, their knowledge and skills, their interests and their strengths. This differs significantly from traditional deficit-focused approaches. This approach also recognises the importance of the person's environment and the situations that impact on their lives.

A central component of the strengths-based approach is collaboration between the person and the worker. Developing a trusting working relationship is essential to the process. The planning process is managed as a partnership between the worker and the person.

The assessment process, using the strengths-based approach, begins this relationship building as well as empowering the person to begin identifying their strengths.

Strengths-based assessment:

- ▶ measures the skills, competencies and characteristics that create a sense of accomplishment for the person
- ▶ identifies what contributes to the person having satisfying relationships with family, friends and members of the community
- ▶ identifies what enhances the person's ability to deal with stress or adversity
- ▶ identifies what supports the person's development (personal, social and cognitive)
- ▶ establishes positive expectations for the future
- ▶ empowers the person to take control over decisions affecting their life.

Family-centred planning

Family-centred planning recognises that for many people, family plays a central role in their lives. Much like person-centred planning, respect for the person and their family is the basis for this approach. It acknowledges that supports provided, or not provided, can impact on the whole family not just the person receiving services. It explores the support family can provide to the person, and how the plan can support the strengths of the family to meet the needs of the person. This means that family members are actively involved in the planning process, and each family member present needs to be listened to and encouraged to participate in a manner that is supportive to the person. The planning process needs to build relationships with family members, support choices of the family and provide family members with good information.



The first step

- ▶ Contact drug and alcohol service
- ▶ Apologise to family
- ▶ Undertake career counselling

Medium-term plans

- ▶ Participate in relationship counselling
- ▶ Reskill

Long-term plans

- ▶ Seek and secure employment

Practice task 11

Work with a person in need or services, or ask a friend or family member to play the role of a person needing services. Undertake person-centred planning using PATH as a framework. Use this table, develop your own or use a template you are familiar with.

Now	
Dreams	
What I have to do	
People who can help	
The first step	
Medium-term plans	
Long-term plans	

Match resources

The goals in an individualised service delivery plan will require resources to achieve. These resources could be friends, family, community groups, health professionals or support workers, who provide general support or can provide specific services. Resources can also be physical resources such as money, time, transport, technology, physical or education. You will need to work with the person to identify the resources required and to find strategies to access these resources as required.



Determine outcomes

An individualised service delivery plan is only effective if you and the person know what outcomes you are aiming towards and what 'success' will look like. This should be done as part of the planning process and should be followed up on regularly.

Here are some examples of goals and the linked outcomes.

Goal	Strategies	Resources	Outcomes
I want a job where I can get paid to work with my hands.	Explore volunteering opportunities to gain experience.	Myself with support worker, one hour per week until opportunity gained.	I have visited places where I could volunteer and chosen one I like. I have spoken to the manager and arranged a meeting next week.
I want to stop smoking.	Get information on smoking cessation options. Choose an option.	Quit campaign information. Support worker to discuss options. Nicotine replacement if required.	I have implemented the strategy and have stopped smoking.

Make variations

Individual plans must be dynamic. This means they must change to reflect changes in the person's circumstances. You should respond to changes in the person's condition or situation by discussing the situation with them. A person's circumstances can change in any one of a number of ways, some of which are considered here.

Plan an integrated approach to service delivery

Recognition of how fragmented service delivery has been in the past is driving a call to provide more integrated services that meet the interrelated needs of individuals. Often a person with complex needs will receive services from multiple service providers, all working in isolation. This has led to people receiving duplicate services, or missing out on required services.

A more effective way of providing services is for service providers to collaborate with the person, and each other, to provide integrated services that address identified needs and goals. This means addressing interrelated needs using one service delivery plan rather than several.

Integrated services require:

- ▶ a commitment from senior levels of government to support integrated services both between government departments and with non-government organisations
- ▶ a clearly articulated commitment to shared goals and a vision of integrated deliver
- ▶ provision, where possible, of 'one-stop shops' or 'no wrong door' services – services that are integrated or collaborative
- ▶ provision of information regarding service delivery to other service providers and to people who require services and their families
- ▶ having, where possible, one service provider providing multiple interventions, or having a range of services in one location or organisation
- ▶ embedding specialist services into generalist services (for example having mental health professionals or a GP embedded in homeless drop in centre)
- ▶ ensuring that service provision is inclusive of culturally and linguistically diverse people, Indigenous Australian people, LGBTI people, people with disabilities and significant others
- ▶ ensuring that services are accessible to people in need of services
- ▶ encouraging community participation
- ▶ providing mentoring to workers to work in an integrated manner.

Example

Consider interrelated needs of the person and planning an integrated approach to service delivery

Service X provides services to homeless people in a capital city. Homeless people can access a daily drop in centre which provides services to meet immediate needs like a meal, hot drinks, laundry and shower services, mail drop off and computer access.

The drop-in centre has integrated additional services into its structure. People accessing the drop-in centre can also access specialist services, such as housing case management, mental health workers, Centrelink officers, a GP, a dentist and legal aid.



Depression, confusion and withdrawal

Signs of depression may include constant disinterest and appearing unmotivated – uncharacteristic sadness reduces quality of life and threatens health and wellbeing.

Confusion or disorientation may involve not understanding simple requests.

Withdrawal involves not participating or responding, therefore becoming socially isolated.

Losing weight, changes in sleeping patterns or unusual use of alcohol or other drugs.

Distress, sleeping and eating problems

Emotional distress signs may include crying, wailing and calling out.

The person may have problems getting to sleep, staying asleep or waking alert. The person may appear tired, be lethargic and become more easily annoyed at situations.

Eating problems may include increased or decreased appetite.

Environmental risks

When preparing an individual plan, it is your role to assess the risks inherent to the environment and develop appropriate strategies to minimise or reduce the risk. You need to determine where the activities detailed in the person's care plan should be carried out, and assess the environment to ensure it is made as safe as possible and that potential risks in the environment are identified and managed or minimised. Many workplaces have a formal environmental risk assessment tool that workers must use to assess the care environment, identify risks and plan their management.

Identify and assess environmental risks

Environmental risk assessments must be conducted for every person and for each environment where support occurs. Even if the environment is a facility where support is delivered to many individuals, it is important to assess again for each individual person, as there are varying risks associated with each individual person and their conditions.

Sometimes risks may be very obvious, such as broken equipment or raised pathways. Other risks may be harder to identify and require you to look very carefully. Risks can be identified by observing the environment and checking for issues or items that may cause risk to the person or worker. Keep the person's needs and abilities in mind. You can also talk and listen to the person and their carer about existing or potential hazards.

Determine locations

Determine the locations where a person may be exposed to risk by referring to the person's individual plan. People receiving services live in and visit a range of environments. The following list contains some examples of locations that can be included on a person's individual care plan.

Consider the following issues during your assessment of the person

▶ Weight

▶ Behaviours of concern

▶ Skin integrity

▶ Impaired judgment

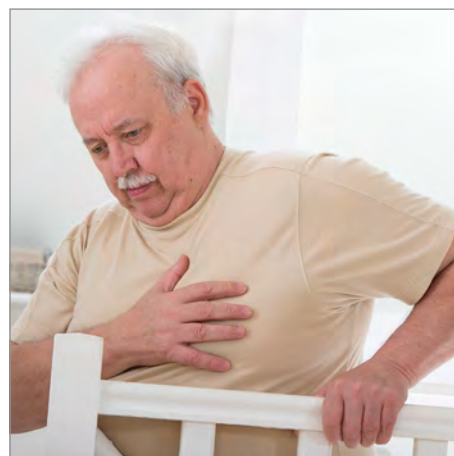
▶ Infection

▶ Impaired cognition

▶ Self-neglect

Weight

Overweight individuals may have difficulty bearing their weight independently when performing tasks such as transferring into showers, and may need support. Workers providing support must be aware of their own safety in assisting these individuals to transfer and weight bear. Most workplaces have a 'no lift' policy, meaning workers are not permitted to lift a person physically at all, and must use lifting equipment. Ensure equipment is appropriate for the person's weight and is safe for a worker to use with heavier individuals. The person's weight should be regularly monitored and managed to ensure that risks are still identified and handled.



Individuals who are underweight may have risks associated with personal care, such as bones that fracture easily or thin skin. Their weight may need to be monitored to ensure it is managed and does not put their health at risk.

Skin integrity

Older people and some people with disabilities may have thinner skin. This means their skin may tear easily if knocked or scraped. It is important that this risk is identified and personal care provided to manage this risk. These individuals may also be susceptible to infection if they have sores or wounds, and must be checked for lesions to ensure this risk is managed. A person with poor circulation or diabetes can also be at high risk of infection from breaks or cracks in their skin.

Infection

A person may have a condition that affects their immunity to disease and infection. Infection may be internal, such as in the lungs or kidneys, or external through breaks in the skin. Be aware of the conditions that may cause a person to be more susceptible to infections and ensure that appropriate methods are used to prevent or minimise their exposure to bacteria and germs. Where a person has poor immunity, it may be necessary to ensure that workers have not been in contact with viruses or infections, that appropriate protective clothing is used and that waste is disposed of appropriately. It may also be necessary to monitor the person's temperature and skin to ensure any signs of infection are detected early and managed.

4C Work with the person and others, to identify and respond to the need for adjustments to individualised plans and support the person's self-determination

As soon as changes are identified, service delivery plans must be adjusted to improve outcomes for individuals and prevent further complications. Procedures for adapting service delivery plans may change between organisations. It is important to consult with the person, their advocate, or their family to find out about their preferences. It is equally important to seek advice, where relevant, from healthcare professionals to find out about best practice for treating the person's disease, illness or condition, to investigate and avoid possible adverse effects, to find likely outcomes and to identify new goals. Remember, it is the person's right to refuse the service.



Identify need for adjustments

The need for adjustments to the service delivery plan can be identified by observing the person engaging in activities or tasks outlined in the plan. They can be identified by discussing how the plan is going with the person and other stakeholders, such as their family or healthcare professionals or other service providers. Keep in mind that the person's circumstances can change, so while the plan may have been effective previously it now needs adjustment. For example, the person may have a change in living arrangements or location, they may have relationships start or end, they may begin or cease employment, they may recover from an illness or injury, they may become less well. All of this can change the type and level of support a person requires, meaning changes to the service delivery plan if necessary.

Types of adjustments

There are a number of things you may do to change a person's plan, including offering additional services or referring the person to another service provider. Presented below are changes that may be made, with examples for each.

Additional services

You may need to offer additional services. For example, Leigh has been receiving home help for the last 12 months. Recently he has been struggling with his personal care requirements. A personal care worker is employed to assist Leigh with his activities of daily living.



Topic 5

In this topic you will learn how to:

- 5A** Clearly record planning activities and decisions made, and prepare reports and other documentation correctly
- 5B** Maintain currency of documentation by making appropriate updates
- 5C** Incorporate review findings into continuous improvement processes

Complete reporting requirements

Documentation of service delivery plans, case notes, and reports is likely to be part of your role. Current information documented accurately assists in providing quality service delivery, ensures that the needs of people are met appropriately and assists in continuously improving organisational processes.

- ▶ Records should be distributed to the people involved in the planning process.
- ▶ Update the person's case notes to indicate when the plan was developed, the outcomes and the follow-up date.
- ▶ Prepare the initial care plan based on the meeting notes and have it checked by your supervisor.
- ▶ Make sure names and medications are spelt correctly, and dates and other details are accurate.
- ▶ Make sure that the person and any other key service providers also have a copy of the developed plan.

Prepare reports

It is likely that you will be required to prepare a variety of reports as part of your role. Reporting will differ depending on the situation, the information being shared and your organisation's policies and procedures. The reporting could be informal or a formal document. At times during service delivery implementation or planning, you will observe something or an incident will occur that requires specific reporting, following organisational policies and procedures. Below are some ways of reporting.

Verbal reporting

In some situations it may be advisable, or adequate, to report verbally. This may be a telephone call or a face-to-face report. Verbal reporting is quick and can share information instantly if an immediate response is required.

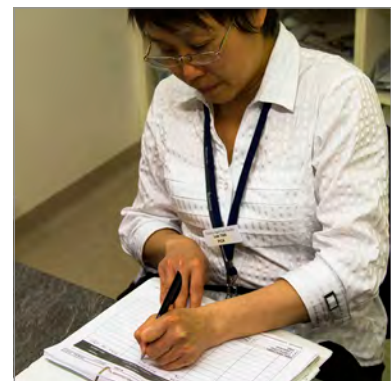
Written reporting

Written reports include file notes on a person's case file, progress reports to stakeholders, incident reports after an incident has occurred, workplace health and safety or hazard reports from various workplaces or service delivery plans.

Prepare other documentation

Many of the documents, reports and records completed by workers are considered legal records of the support provided to individuals and how the organisation manages WHS and infection control. Most government-funded organisations undergo regular audits, where records are examined to ensure work is carried out to the appropriate standard. Furthermore, different types of information may need to be documented at different times, and several people may enter information on a single record.

The protocols for recording information should be detailed in organisational policies and procedures, and confidentiality and record management must meet legislative requirements. Seek advice from your manager if you have questions about recording information.



Case documentation

Case documentation can include:

- ▶ medical records and test results
- ▶ progress notes
- ▶ completed questionnaires
- ▶ completed assessment tools
- ▶ service delivery plans
- ▶ records of client feedback.

Medical reports help assess a person's needs, as they provide a wide range of information about a person's current physical and mental health, and future prognoses. This information may also be used to assess a person's eligibility for other support services.

WHS reports

All support workers have health and safety responsibilities. Communicating with others about risks is part of these responsibilities. If you witness a workplace accident involving a person receiving services or another person, you may be required to fill out an accident report form. Recording near misses or incidents also helps make improvements to workplace safety to minimise hazards or risks.

Service data

Service data includes hours spent on each activity with each person in each program area, and is usually entered directly into an electronic database, as required by the funding body, government department or organisation's board. Data is often collected daily and submitted quarterly.

Organisational reports

Organisational reports include annual reports, strategic plans and business plans. These are generally produced on an annual basis.

Project and program reports require regular progress reports at intervals throughout project or program delivery. Evaluation reports are provided following the completion of a project.

Human resources

A time sheet records the hours you have worked and, in some cases, the people you have seen and details such as kilometres driven. An accurate time sheet determines your pay and may also be used for invoicing a person receiving services or funding bodies for hours of service provided.

Coordinators and managers need to keep track of staff training and development, including formal and informal training.

When staff performance is assessed, a record of the outcomes and a plan for development or improvement are completed. Some organisations may ask you to complete a self-appraisal to say how you think you are performing and how you could develop and improve in your role.