Errata

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Title: CHCCSM004 Coordinate complex case requirements – Learner guide

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Page numbers: 1, 10, 17, 36, 37, 60, 81 and 82

Attachments
NEW p. 1, 10, 17, 36, 37, 60, 81 and 82: CHCCSM004 Coordinate complex case requirements

Please use the attached pages to replace erroneous pages in the above resource.

Aspire Learning Resources

Topic 1

In this topic you will learn about:

Understanding case management

Case management is a process in which a case coordinator or case manager assesses a client and assists them to access options and services.

Case management is a collaborative process of assessment, planning, facilitation, advocacy and coordination of options and services to meet an individual's holistic needs. This is achieved by using efficient communication and accessing available resources to promote high-quality, cost-effective outcomes.

Watch the unit introduction video here.

Client rights and responsibilities

Clients of all community services organisations have service user rights and responsibilities.

These are specific to each sector, and are drawn from the wider legislation and standards that govern each sector. They form part of the legal and ethical framework used by case coordinators when supporting clients in various sectors.

Two examples of sector-specific client rights and responsibilities are:

- Charter of Care Recipients' Rights and Responsibilities – Residential Care
- Charter of Care Recipients' Rights and Responsibilities – Home Care

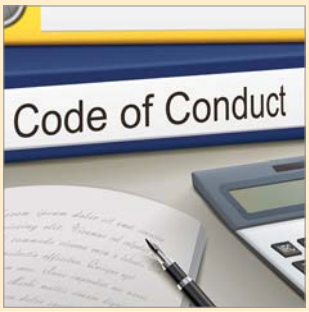
Understand your role

It is critical to understand the requirements and limitations of your role as a case coordinator.

Role requirements

The requirements and responsibilities that apply to a case coordinator's role are outlined in the position description. This details the scope of the role, the duties and activities that a staff member is legally able to perform. This might include not exceeding the authority of their position and staying within professional boundaries. It is vital that case coordinators undertake only the activities and duties that are specified by their role. Performing duties outside the job description may have legal implications for the organisation and the person involved.

Boundaries of role



Professional boundaries are stipulated in industry or organisational codes of conduct.

Boundaries can become blurred when they are not clearly defined and understood by both the case coordinator and the client. It is important that the client understands the ethical and legal boundaries that the case coordinator must work within. As the case coordinator, you must not only understand these boundaries, but also work within them.

Watch this video to learn about the key requirements of your role.

Duty of care

Duty of care is part of common law; it requires you to do whatever is fair and reasonable to prevent harm or injury to a person or their property.

Duty of care describes the legal obligation that individuals and organisations have to anticipate and act on possible causes of injury and illness that exist in their work environment or come about as a result of their actions. There are serious implications if duty of care is not upheld.

Negligence

Negligence occurs when duty of care has been breached and harm to a 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.

Dignity of risk

The rights of people to dignity and choice, upheld in legislation and service standards, state that duty of care and safety concerns must not be used as a reason to limit a person's freedom or personal choice. A case coordinator must respect the concept of dignity of risk, which means that a person has the right to make their own choices and to take certain risks as part of their personal freedom.

Duty of care responsibilities

All staff must diligently uphold their duty of care to clients.

Clients with complex needs may experience a range of risks in relation to their physical, psychological and psychosocial safety. Addressing the actual and potential effects of harm becomes imperative in organisational duty of care obligations.

Identifying and responding to areas of complex risk requires involvement from qualified professionals as well as services with capacity and expertise to respond. Case coordinators who have any reason to suspect that clients are at risk must respond and report according to relevant organisational protocols.

Watch this video to learn about your duty of care responsibilities.

Co-existing needs

If not managed effectively, single needs can accelerate into more complex needs, and become much more difficult to control.

Case coordinators need to understand the relationship between the client's co-existing needs and attempt to reduce the likelihood that the presenting needs will interact to create additional issues.

Read Merv's story about his co-existing needs.

Merv's story

Merv, 79, lives in a residential aged care facility and has osteoarthritis in both knees. He needs help to stand up and walk. He has Type II diabetes, which is controlled through his diet, and he relies on facility staff for dietary support.

Care staff are busy, and can take a long time to respond when Merv calls for toileting assistance. This has caused episodes of urinary incontinence. Staff have encouraged Merv to wear a continence aid, telling him it will help if they can't get to him in time. Merv has complied reluctantly, but his skin has become chafed due to urine in the continence aid.

Merv has become depressed and anxious. He says his dignity has been compromised by this avoidable situation. He has stopped attending afternoon activities and is reluctant to go to the dining room for his meals because he is fearful he will 'have an accident'. His appetite has declined, and he is eating less, which has an adverse effect on his blood glucose levels. Merv's self-imposed isolation is increasing his loneliness and depression, and he is no longer motivated to get up for his morning shower. With his decreased movement and physical activity, Merv is in more pain because the muscles around his knees have de-conditioned due to diminished use.

A review of Merv's care needs indicates that he now requires interventions to address the following multiple needs:

- functional incontinence
- depression
- self-isolation
- decreased mobility
- increased pain and swelling of the knees, requiring additional pain relief and physiotherapy
- diabetes management and dietary issues
- chafing of the skin around the groin.

If appropriate interventions had been put in place, ensuring the response times to Merv were faster, Merv's original co-existing needs would not have reached this level of complexity.

Watch this video of Merv's story.

Address client issues

Many clients face a range of issues when accessing multiple services.

As a case coordinator, you need to work with the client and other stakeholders to address each of these needs and issues. Issues that need to be considered when planning and coordinating support services include:

- disempowerment
- implications for family and unpaid carers
- client confusion, concerns and barriers
- generational abuse
- welfare dependency.

Watch this video to learn about addressing client issues.

Disempowerment

Disempowerment is a common experience for clients accessing multiple services.

Many clients' lives are full of appointments for therapies and services, with little time or opportunity for recreation. Often their complex issues reduce their quality of life (QOL) and they may be worn out trying to cope. Clients may feel that they have little control over their lives. Multiple staff coming into their home to provide services can lead to feelings of invasion of privacy.

Working with the aim of empowerment is important. At all times, respect must be shown to the client. Case coordinators and staff should ensure they do not work in an authoritarian manner, which will further disempower the client.

Implications for family and unpaid carers

When clients have to access multiple services, this can adversely affect their family members.

The presence of support staff in the home may be an issue. Additionally, much of the focus of the family may be on the client's needs, such as attending appointments, leaving little time for family activities, or for other members of the family to have their needs met.

Case coordinators can help clients' families to address these issues by informing them about support services. For example, a family may be able to access respite services, or funding for recreational activities/camps for children to attend. Case coordinators must be careful not to blur the boundaries of their role, remembering that their primary focus is to coordinate the case requirements of the client.

3A Developing a client plan

Developing the client plan calls on all the skills and knowledge of the case manager.

Planning services and support strategies and interventions should be a collaborative process, involving the client, others who are significant to the client, any advocate, representative or substitute decision-makers who choose or need to be involved, and relevant stakeholders from organisations who will be providing services.

Planning should occur at a formal planning meeting (or series of meetings). These meetings must be person-centred and client-driven.

Assessment outcomes and information gathered during the assessment phase are used to develop client plans. Depending on the organisation and sector of the community services industry, the client plan may be referred to by another name.

Common names used for client plans include:

- care plan
- case plan
- person-centred plan
- support plan
- service agreement
- National Disability Insurance Scheme (NDIS) plan
- individual service plan (ISP).

Determine service needs

Determining the service provision requirements of a client usually begins at the point of intake.

This is the point at which the client has been accepted into the service, and has been allocated a case coordinator.

Read Alex's story to see how his needs were determined.

You can also watch a video of Alex's story here.

Here are six effects that service duplication can have on client care.

1. **Compromised future funding**
   Funding bodies require reports from service providers outlining how funding has been used and whether client goals have been met. If significant service duplication has occurred and goals have not been met, funding bodies may withhold future funding because existing funding has not been appropriately managed.

2. **Increased client confusion**
   Clients accessing multiple services may struggle to understand or keep track of when a particular service is being provided, and by which service provider. Service duplication can increase this confusion when the client does not understand which services they have been allocated.

3. **Increased legal risk**
   Staff may not be covered by workers' compensation if they have not been authorised to undertake the duties they are carrying out.

4. **Scope of practice boundaries are breached**
   There are legal risks for the organisation and safety risks for clients if staff undertake duties they are not qualified or authorised to carry out.

5. **Outcomes not achieved**
   If one service is being duplicated, it is possible that another service is not being provided. Therefore, the outcomes that are intended to be achieved may not eventuate. A client's condition could worsen if they are not receiving a particular service due to duplication.

6. **Client loses faith in the service**
   If the services are not producing the desired outcomes or duplication is causing confusion and stress for the client and their family, the client may lose faith in staff and cease to access the services. This may have significant adverse effects on the client's health and wellbeing.

Identify and manage service duplication

Unless an effective monitoring system is implemented, service duplication may not be revealed for some time. Many staff work in clients' homes, and in other locations in which they are not directly supervised by their line managers. Sometimes staff act outside of established rules or client plans.

Staff may misunderstand or forget to consult the client plan. They need to be monitored to make sure everything is running smoothly, and that staff are sticking to the roles and actions in the client plan.

Watch this video about service duplication.

Sharon's story

Sharon is 82 years old and living in her own home. She receives a range of support through a Home Care Package, which is provided by multiple services.

Sharon has severe osteoarthritis in her knees and back, which significantly limits her mobility and capacity to undertake self-care. Sharon struggles to prepare meals, and has been assessed as having a high falls risk. Sharon also has diabetes and requires weekly blood glucose level (BGL) monitoring. Her declining vision means that she can no longer drive, so she needs assistance to go shopping and pay the bills. Sharon experiences depression, which is exacerbated by her social isolation, and has chronic obstructive pulmonary disease.

Sharon's suite of services, including her Home Care Package, is coordinated by Carmen, her case manager. Some services are provided by direct support staff from Carmen's organisation; others are contracted out to other providers through a brokerage arrangement. Carmen makes sure that all of the services cover Sharon's needs, and that none of them are duplicating or doubling up on the same tasks or services.

The services include:

- Weekly home care and domestic support: Home Care Package, staff member: Susan
- Twice weekly personal care (showering): Home Care Package, staff member: Tina
- Lunches delivered twice a week: Contracted provider
- Weekly home visit from a registered nurse to monitor BGL: Contracted nursing service
- Fortnightly social support to go out for lunch or do a social activity with a staff member: Contracted social support service
- Fortnightly transport services for shopping and paying bills: Home Care Package, staff member: Alison

Prevent service duplication

It is critical that the roles and boundaries of all service providers are determined and formally recorded in the context of client plans, so that all parties are clear about the services they will be delivering.

As a case coordinator, you can take steps to reduce the likelihood of service duplication occurring.

Practices to prevent service duplication

- Seek regular client feedback.
- Monitor service delivery through documentation.
- Establish written and verbal reporting mechanisms for staff who work in clients' homes to provide regular reports of the duties they are undertaking.
- Participate in staff training and instruction.
- Manage unsatisfactory staff performance by following organisational procedures for counselling, retraining and monitoring employees who do not follow care plans.
- Conduct regular review meetings.
- Liaise regularly with all organisations involved in the client's service delivery.