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Topic 1

In this topic you will learn how to:

- 1A Identify and prioritise the needs and coexisting issues of the person**
- 1B Identify specific problems, issues and challenges for the person**
- 1C Analyse and interpret data with assistance from health professionals**
- 1D Recognise the impact of complex support issues on the person's family**
- 1E Establish priorities for support with the person and relevant others**

Evaluate and prioritise the needs of a person with complex support issues

A person with complex support issues typically has a number of areas of need and various issues that need to be carefully identified and prioritised. The process of prioritising means that the most important and time critical issues are assessed first, often using data that is provided by allied health professionals or medical professionals. This process may demand support and assistance from other professionals as well as from family members or caregivers and from the person.

Prioritising issues and areas of need allows for the development of an appropriate plan that takes into account individual requirements and available resources and support services. It is important, during the process of evaluating and prioritising the needs of a person with complex support issues, to recognise the impact these issues may have upon family members.

4

Collect and collate

Collect and collate information from the formal and informal assessments provided by stakeholders.

5

Identify and complete gaps

Identify any gaps in knowledge about the person and collect further information, as needed, through formal and informal assessment.

Formal assessment

Formal assessments can provide information about many aspects of daily functioning, specific needs and health and related information. They should only be completed by people who have the necessary skills and knowledge to use the assessment tools. Many assessment tools require specific levels of qualification or experience before they can be used – check your own workplace requirements for using formal assessments.

Here are three types of formal assessments that may be used with people who have various types of disabilities or needs, or who are from specific cultural backgrounds.

Mental state examination (MSE)

- ▶ An MSE gives a snapshot of a person's psychological functioning at a particular point in time and can indicate if referral or risk assessment is needed.

Australian community care needs assessment (ACCNA)

- ▶ The ACCNA provides a consistent tool that is used across many service types to collect and record information about the person and their carer (if relevant).

Indigenous risk impact screen (IRIS) and brief intervention

- ▶ The IRIS screening tool assesses risk for alcohol, drug and mental health issues in Aboriginal and Torres Strait Islander peoples.

Informal assessment

Many workers use informal assessments every day, often without even realising it. The observations we make about a person and the things they tell us about their needs help create a picture of how to best provide support and assistance.

Informal assessments may be created within the workplace or they may be comprised of the notes and observations you make during an initial meeting or conversation.

Elements of an informal assessment may include:

- ▶ written notes about what the person tells you
- ▶ observations of their mobility and independence
- ▶ observations of the physical assistance required to perform activities of daily living
- ▶ discussion of how their needs impact upon their activities
- ▶ discussion of their goals and requirements
- ▶ information given to you by family members or advocates
- ▶ answers given to questions you ask about care and support needs.

Some coexisting issues that must be considered are:

- ▶ presence of mental/physical health conditions
- ▶ transport difficulties
- ▶ social or geographical isolation
- ▶ financial considerations/level of debt
- ▶ religious or cultural requirements
- ▶ carer or other family responsibilities.

Prioritising needs

It is important to prioritise needs when providing care and support for a person. Identify the needs that are most important – these are the needs that must be dealt with first. Care and support may be required for a short period of time, such as in response to a crisis or as part of a planned respite or short-term activity. Sometimes ongoing care is required to support daily activities or a regular schedule of tasks such as employment, recreation or personal care requirements. Establishing how urgent the needs are determine the priority of meeting a person's needs. Here is an example of how needs can be prioritised.



Crisis support

Crisis support can be provided to help manage a short-term crisis such as a family illness, change to living situation or a sudden change in health status or care needs.



Intermittent care

Intermittent care can be provided from time to time, when required; for example, if a person's condition exacerbates or when they are having respite care.



Transition care

Transition care facilitates the transition from one setting to another, such as moving from home to a residential setting.



Ongoing support

Ongoing support happens according to a regular planned schedule, such as weekly or daily care, to ensure the maintenance of usual life functioning and arrangements.

1B Identify specific problems, issues and challenges for the person

Care and support must be provided in line with person-centred practices. This requires focusing on individual support requirements and needs. Sometimes, a person may have specific issues or challenges in their life that need to be identified. These may relate to their disability or condition, or they may be a feature of their particular situation. Knowing what these issues and challenges are can help you plan the delivery of services according to individual requirements. When you identify issues and needs of a person in your care, make sure you consider the limitations of your own job role, follow organisational procedures and seek assistance as appropriate.



Identify specific issues and challenges for the person

The issues and challenges experienced by a person may directly relate to a specific type of disability or they may be typical of the disability or condition. This could include problems such as:

- ▶ accessing buildings and facilities
- ▶ finding an accessible toilet
- ▶ being treated in an unfair or discriminatory way.

To identify specific issues and challenges for a person you are caring for it is important to understand how physiology and psychology applies to their disability.

How physiology applies to disability

Many disabilities affect the physiological functioning of the body; that is, the way the body works at a system level (for example, respiratory, cardiovascular, endocrine systems) and organ level (for example, the heart, lungs, skin or pancreas). It is useful to understand how the human body functions and what happens to the various organs and systems when a disability is present. Physiological effects can range from mild to profound.

Here are some examples of how physiology applies to a range of disabilities.

Disability type

Physical disability

Depending on the type and level of physical disability, a person may display signs of a compromised musculoskeletal system. This may be identified by observing the person's mobility and their ability to complete manual tasks.

Sensory disability

Depending on the type and level of sensory disability, a person may display signs of a compromised sensory system. This may be identified by the person's inability to taste, smell, see or hear.

Common issues and challenges

A person with a disability may experience many issues and challenges. It is important to understand and identify issues and challenges as soon as they arise. This enables you to predict difficulties and plan for issues should they occur.

Here are some challenges and issues that may affect a person with a disability. A person with complex needs may have issues and challenges from several disability types.

Disability type

Physical disability

The challenges and issues experienced by a person with a physical disability may relate to:

- ▶ accessing services and public transport, etc.
- ▶ using devices that require motor skills
- ▶ completing compound actions, such as reaching and pulling
- ▶ maintaining independence.

Sensory disability

The challenges and issues experienced by a person with a sensory disability may relate to:

- ▶ sight: reading, walking, completing household tasks
- ▶ hearing: communicating within the community such as hearing public transport announcements
- ▶ taste: completing household tasks such as seasoning foods, tasting foods (whether it is still good to eat)
- ▶ smell: completing household tasks such as cooking; safety, such as smelling smoke or gas

Psychiatric disability

The challenges and issues experienced by a person with a psychiatric disability include the ability to :

- ▶ think clearly
- ▶ make decisions
- ▶ understand other people's feelings or actions
- ▶ show emotions
- ▶ complete self-care activities.

Neurological disability

The challenges and issues experienced by a person with a neurological disability may be:

- ▶ loss of memory
- ▶ attention deficits
- ▶ incoherent speech.

1C Analyse and interpret data with assistance from health professionals

Allied health professionals and other workers can provide formal assessment information and data, which can assist in determining the best way to provide support and care. Data may be in the form of reports or assessments, and must be interpreted carefully and appropriately by qualified people.



Types of data

There are many types of data that may be gathered, and depending on the type of data, it may be analysed and interpreted differently. Depending on the person, there may be a range of people who contribute data to help evaluate the person's individual needs.

Here are some types of data that may need to be analysed and interpreted, and who the information may be supplied by.

Types of data to analyse and interpret

Informal written or verbal reports

Informal written or verbal reports provide brief information that is easy to interpret and understand.

Supplied by: supervisors, other care workers and/or the family of the person receiving support

Medical reports

Medical reports have more-complex information including specific medical language, facts, figures and numerical data.

Supplied by: general practitioners, nursing staff, allied health professionals

Functional skills reports

Functional skills reports have information about how a person operates in various situations, such as walking skills assessments or transferring and mobility skills reports.

Supplied by: physiotherapists, speech pathologist, occupational therapists

Risk assessments

Risk assessments provide information to staff about the relative risks of various situations, and how they should respond, such as the risk of a person falling.

Supplied by: care service manager, supervisor, health and safety representative

Incidence and prevalence data

Incidence and prevalence data provides information about specific disabilities and how frequently they occur among the population as a whole, or within particular cohorts such as children, adults or older people.

Adapted from the Australian Bureau of Statistics: Disability, Aging and Carers, Australia: summary of Findings; www.abs.gov.au

Example

Analyse and interpret data

You work with children who have been identified as coming from 'at risk' living situations. Your supervisor has asked you to research a screening tool that can be used to identify any children who may have an as yet undiagnosed developmental delay or disability. You consult with the local community health centre and the early childhood intervention team in your area and seek their advice.

They both recommend the PEDS tool (Parents' Evaluation of Developmental Status) because it is simple, easy to administer and the data can be scored and interpreted in around five minutes. You trial the PEDS for several weeks and then ask for feedback from parents, carers, staff members and your management team. The feedback is generally positive, so you write a recommendation that the PEDS tool be adopted as a regular aspect of service provision in your service.

You also recommend that all staff be fully trained in administering, scoring, analysing and interpreting the results, and in knowing when and how to refer any concerns on for further evaluation.



Practice task 3

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

Case study

Mavis works in a community day centre where she provides and facilitates recreation and leisure activities. She has been given a report regarding a new person in her care and is unsure about analysing and interpreting the data it contains. The report is called the Alzheimer's Disease Assessment Scale (ADAS). Mavis has not seen an ADAS report before.

Mavis knows the report is about a person who is going to join the gentle exercise program on Thursday afternoon. She reads the scores, which have been written into a booklet, but realises that the report does not include a summary section or interpretation of the results.

She reads the testing booklet that includes the person's responses, but there are no written comments or interpretations from the community services professional about the person.

1. To help Mavis understand the data in the report, who should Mavis contact first?
.....
2. Mavis is eager to have the person join her program but is unsure about what the data means. What should Mavis do?
.....

Click to complete Practice task 3

There are two key concepts to help you understand complex support issues:

- ▶ 'Breadth of need', which refers to multiple needs that are interconnected
- ▶ 'Depth of need', which refers to the profoundness and intensity of needs

Consider the following information.

Breadth-wide range of areas

Breadth-wide range of areas include the following:

- ▶ Disadvantage
- ▶ Disability
- ▶ Health issues
- ▶ High physical support needs
- ▶ Mental support needs
- ▶ Poverty
- ▶ Unstable living situation
- ▶ Financial difficulties
- ▶ Family violence
- ▶ Substance abuse

Depth-complex impacts

Depth-complex impacts include the following:

- ▶ Significant impact on the person and their family
- ▶ Serious issues
- ▶ Far-reaching implications
- ▶ Not easy to resolve
- ▶ Require careful and experienced planning
- ▶ Require ongoing support

Impact of complex support issues

Support issues for people with complex needs vary according to their environmental and societal context. For example, parents may find it a challenge to care for their children with complex needs. Couples, where one person has complex needs, may find they are under extreme pressure and that their relationship becomes more conflict-ridden and unstable. Single parents with complex needs may need to rely on family and community support. Culturally and linguistically diverse (CALD) families are vulnerable to experiencing complex issues. Isolation and communication difficulties may manifest as depression and anxiety. Providing support for a wide range of issues requires a multi-service and integrated approach.



1E Establish priorities for support with the person and relevant others

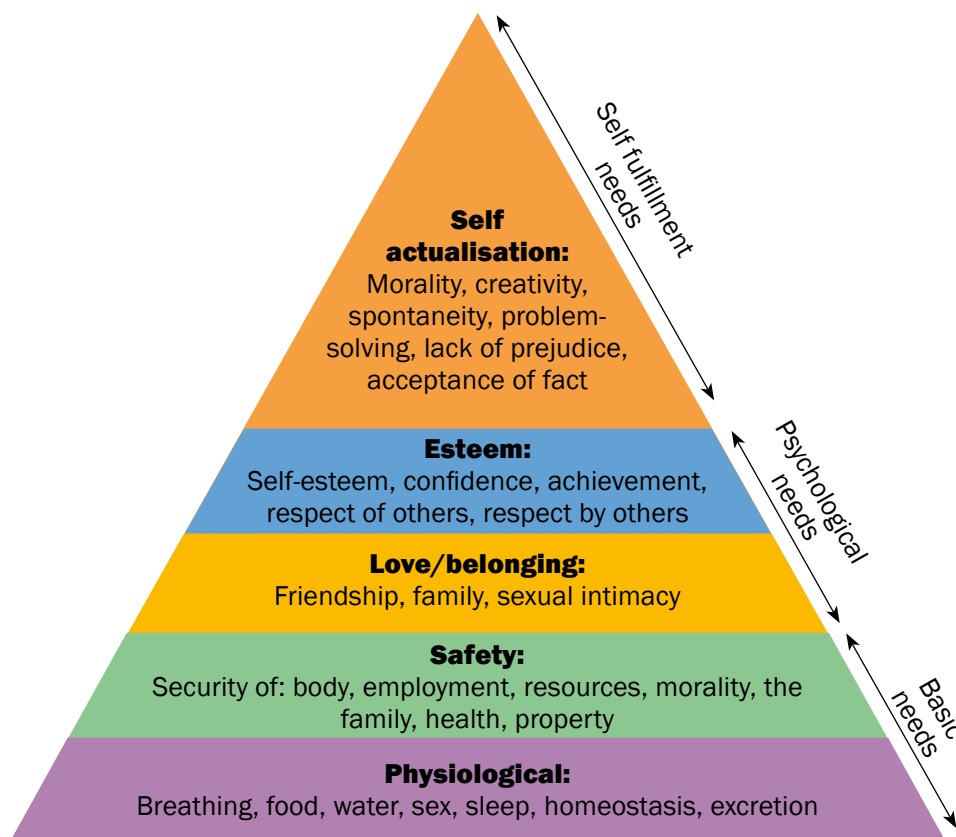
When working with a person who requires complex support, their needs must be prioritised so they are properly managed.

Prioritising needs may be done in collaboration with other people, including the person themselves, family members, health professionals and other stakeholders.

Establish priorities

Some support needs are time critical and urgent, and some family situations require immediate attention. Whatever the case, there should be a focus on trying to re-establish a safe, secure and appropriate family or living situation that is maintainable in the long term.

Early priorities include basic areas such as food, shelter and safety; while later priorities include emotional and social support. Maslow's hierarchy of needs illustrates the level of an individual's needs and can be used to systematically establish the priority of needs.



Practice task 5

1. List three high-priority issues that need to be addressed when prioritising support needs in the individualised support plan.

2. Describe two ways you can prioritise support when developing a support plan for a person with complex needs and issues.

Click to complete Practice task 5

Summary

1. People who require support services may have simple or complex needs. When a person has issues that coexist, their needs become complex and the needs must be prioritised.
2. An assessment takes place to identify whether a person's needs are simple or complex. This may be a combination of formal and informal assessments.
3. Analysing and interpreting data may be done with assistance and in collaboration with others.
4. It is important to understand the breadth and depth of issues that can affect a person with complex needs and their family.
5. Collaborating with others will help you to understand the needs of the person requiring support and ensure the priority of support and level of support provided is appropriate.

2A Use best practice guidelines to develop strategies to address complex and/or special needs

The community services sector has best practice guidelines that inform support workers about the best way to perform work tasks and carry out assessments. These guidelines assist workers to develop strategies to address people's complex or special needs.

Best practice guidelines may be contained within community care standards or quality frameworks. It is important that strategies for addressing complex or special needs are underpinned by best practice guidelines to ensure the best and most appropriate support is provided.



Common health problems and behavioural issues

Common health problems and behaviours of concern must be considered when developing an individualised plan. Different disability types have health problems and behaviours of concern associated with them. However, this is not always the case, so it is vital to consider the individual needs of the person and avoid making assumptions about specific care needs. For example, a person with a physical disability may develop health problems due to lack of mobility. Depending on the type of disability, behaviours of concern may also present.



Manifestation and presentation of health issues

How a particular health problem or behaviour of concern manifests varies from person to person, even when two people have a similar condition. You should never assume that people with the same condition or disability will have the same behavioural issues; every person is different and will display different behaviours.

Here are different types of disabilities and the health problems and behaviours of concern that may present.

Physical disability

A person with a physical disability may present with muscular skeletal issues. Depending on the disability and the level of impairment, health issues may include respiratory distress, cardiovascular issues or blood pressure concerns. Mental health issues such as depression and anxiety may present.

Behaviours of concern may include social withdrawal or anger.

Strategies to address needs

Strategies to address the needs of the person should be included in the individualised support plan. The strategies used will depend on the person's health and behavioural support needs, and will describe how the person will be supported and the way it will happen. Depending on how complex the needs of the person are, more than one strategy may be required to address their needs.

Strategies must be clear and specific, be linked to the person's aims and goals, and be supported by best practice guidelines.

Strategies used to inform an individualised care plan may be found in best practice guidelines and the policies and procedures of the community services organisation you work for.



Best practice guidelines

Section 3 of the Home Care Common Standards provides information and guidance on how to apply best practice methodology within a community care organisation. The Standards apply to a range of care providers within community services.

There are three discrete standards within the Home Care Common Standards, and 18 expected outcomes. The outcomes relate to each standard and the practices and processes that should be followed to ensure the achievement of expected outcomes.

More information on the Home Care Common Standards can be accessed at: www.aacqa.gov.au/for-providers/home-care

Standard 1: Effective management

- ▶ This standard refers to demonstrating effective management processes that are based on the continuous improvement of service management, planning and delivery.

Standard 2: Appropriate access and service delivery

- ▶ This standard refers to each service user having access to services and receiving services that are planned, delivered and evaluated in partnership with themselves and/or a representative.

Standard 3: Service user rights and responsibilities

- ▶ This standard refers to service users being provided with information to assist them in making service choices, and their rights to be consulted and respected in the decision-making process. Service users must have access to complaints and advocacy information and processes, and have their privacy, confidentiality and independence respected.

2D Access and negotiate resources to deliver identified services

Once service needs have been identified for a person requiring support, resources need to be accessed and negotiated. Resources may be accessed from your organisation or other agencies. Some resources may need to be negotiated, such as funds or training, in order to deliver appropriate services.

The area of community services in which you work, and the needs of the person in care, dictate what agencies need to be accessed for support. As a community services worker, you may need to access and negotiate resources so the needs of the person are met appropriately.



Resources

Resources are the things that are needed to enable the appropriate delivery of services to a person requiring support. Resources may include equipment, specialist training, human resources, financial support or housing. Depending on the specific needs, the level of needs and the complexity of needs of the person, access to more than one agency may be required. Aligning the resources required may require negotiation and consultation with the person requiring support, their family and/or carers and the agency providing the service.

Types of resources

Understanding and establishing the individual needs of the person in care is crucial to accessing appropriate resources to support their care. When a person has complex needs it may be necessary to access support from health and community services.

Here are some examples of types of resources that may be required.

Aids and equipment

Aids and equipment may be needed to enhance the person's independence. Resources may include mobility aids, home modifications, vehicle modifications or domiciliary oxygen. Communication enhancement equipment, such as speech generating devices and software, may be required.

Financial support

Concessions, carer's allowance or financial counsellors may be accessed to aid a person in need of financial support.

Housing

Depending on the circumstances of the person requiring support, they may require supported accommodation, community housing or support to live in their own home.

Learning checkpoint 2

Develop an individualised plan to achieve maximum quality of life

This learning checkpoint allows you to review your skills and knowledge in developing an individualised plan to achieve maximum quality of life.

Part A

1. List the three standards in the Home Care Common Standards that provide information and guidance on best practice within community care.

2. List three types of disability and for each type, provide a nutritional and dietary consideration.

3. List two reasons why goals may need to be negotiated in an individualised care plan.

4. When creating an individualised care plan, what are two important considerations you need to think about when establishing goals.

5. List two factors that may influence access to resources.



Topic 3

In this topic you will learn how to:

- 3A Ensure services and support activities are undertaken by appropriately skilled workers**
- 3B Recognise when a service and/or worker is unable to provide the level of service required**
- 3C Support stakeholders providing a service to understand their roles and responsibilities within the plan**

Coordinate the delivery of the individualised plan

Coordinating the delivery of an individualised plan for a person in care is an important job that involves careful planning, supervision, support, good communication and a commitment to ongoing evaluation to ensure the plan is meeting the person's goals and needs. Community services workers must have the skills and knowledge to undertake specific tasks and activities. It is critical to identify when a service cannot meet its service commitments or when a community services worker cannot meet the requirements of their role. Wherever possible, workers should support others effectively so they can fulfil their role in coordinating the delivery the individualised plan.



Behaviours of concern

Maintain appropriate skills

Depending on where you work, the organisation may actively provide opportunities for staff to participate in training and information sessions. This may include a formal training plan that includes goals and priorities, or it may be involve more-informal training such as refresher courses, mentoring or workshops. The aim of any training session is to ensure appropriate skills are developed and maintained.



In some cases, a community support worker may become aware of a gap in their skills while caring for a person with changing needs. The skill set initially required for care provision may have been appropriate, but when the needs become more complex and specialised, different skills are required.

The support worker should speak with their supervisor or manager if they feel they do not have the appropriate skills to complete a task within their role.

Example

Provide skills development

Archie is a team leader who organises support workers who provide support to Tom at home. Tom has motor neurone disease, and his needs are changing, which affects the level of care required.

Recently, transfers from Tom's wheelchair to a shower chair have become more challenging. Some of the support workers are finding it increasingly difficult to manage the transfer comfortably and safely.

Archie organises a training session for the workers with Sue, a physiotherapist. Sue demonstrates the appropriate way to transfer a person from a wheelchair to the shower chair. Sue has the workers practise with each other, so they can gain the skills they need to assist Tom appropriately. Sue also talks to the workers about how Tom's needs and care provision may change in the coming months.

Archie records the training session so the workers can refer back to it as needed. Sue also provides an illustrated flowchart of the steps for completing a transfer, which can be used for reference.

Archie is pleased to hear that the workers feel much more confident in performing the transfers and that they have used both the video and flowchart as a reference tool.



Example**Indicators of support changes**

Jenny has been providing support to Mark for several months. Mark has had a stroke and has increasing difficulty with communication. Mark becomes frustrated and angry when Jenny can't understand what he is trying to tell her. Jenny is finding it more and more difficult to cope with Mark's anger and frustration. It is affecting her work, and she struggles to provide physical care for Mark when he is angry.

Jenny talks with her supervisor, Kate. When speaking with Jenny, Kate recognises that Jenny needs support and adjustments to her work arrangements. Kate organises for Jenny to have support to enable her to work more confidently with behaviours of concern. Together they decide that Jenny shifts will be adjusted so her interaction with Mark will be reduced until Jenny feels she is able to work with Mark comfortably. Jenny begins doing some shifts with people who do not have behaviours of concern while she receives additional training.



Practice task 12

Case study

Charlotte is 10 years old and has cystic fibrosis. When she was younger, she required full-time supervision and specific care to support her physical and dietary needs. Charlotte progressed to a three-monthly care plan; however, there have recent been changes to her health.

Charlotte's health has suddenly deteriorated and she now requires daily medical care, supervision and feeding assistance. Her case manager, James, realises that Charlotte's care plan requires significant adjustment, as she now requires specialist care and a higher level of support.

1. What two things could James do to manage the change to Charlotte's care plan to ensure she receives the appropriate level of care?

2. What is the key indicator that Charlotte's care requirements are no longer being met in her current care plan?

Click to complete Practice task 12

4A Seek feedback from all stakeholders when evaluating the effectiveness of the plan and re-prioritising support needs

You may need to seek feedback from a variety of people when evaluating the effectiveness of the care plan. Contact may be made with case managers, mental health nurses, general practitioners, outreach workers, psychologists, allied health professionals or direct service providers. Feedback is used to evaluate the effectiveness of the plan that is currently in place for a person requiring support.



Seek feedback from all stakeholders

There may be a range of stakeholders who can supply feedback to help evaluate the effectiveness of the care plan of a person with complex needs. The feedback is also used to prioritise the person's needs.

Here are some examples of feedback that may be offered by stakeholders to help evaluate a plan:



Feedback to help evaluate a plan

Allied health professionals

Physiotherapists, occupational therapists and speech pathologists, etc. can evaluate physical functioning, skills and safety and help re-prioritise goals.

Case managers

Case managers can be involved in evaluating how all the supports for a person work together and can advise on general life goals and skill areas.

Direct service providers

Direct service providers can evaluate direct care support such as personal care and social supports and help evaluate if staff skills are still suited to the needs of the person.

Mental health professionals

Psychologists, mental health nurses and general practitioners can advise on mental health issues and set new goals and identify potential issues that may require a change in the plan.

Person receiving support

The person receiving support is best able to identify problem areas in their existing plan and advise you on what needs to change in the future.

Physiotherapist

- ▶ A physiotherapist can provide advice and training on positioning, movement and completion of physical tasks and activities.

Example

Seek advice and assistance

Ben lives in a community care. He has communication challenges, so he uses assistive technology (AT) for communicating with his carers and his family. One of Ben's goals is to be able to go to the local shops and communicate with the shopkeepers without his carer speaking for him. Being able to communicate on his own is very important to Ben.

Phillipa, Ben's case manager, is reviewing his care plan to check his progress and notices that the agreed goal of being able to visit the local shops independently has not met the target date. Phillipa consults with Ben, his carer and his family to find out the reason that the target date has not been met.

Ben says that sometimes the AT batteries are flat on the weekend. This means that even when recharged batteries are inserted the AT needs to be reset. After a discussion with Ben's carer, Phillipa realises that during the week, the community care workers are trained in programming the AT and recharging the batteries. However, on the weekend, the community care centre is staffed by casual care workers who are not trained in using and maintaining the AT Ben uses. Sometimes the batteries need to be recharged or the AT reset, but the casual care workers are not trained how to do this, which means Ben is unable to use the AT when he needs to.

Phillipa organises a training session with an AT expert who shows all the carers how to maintain the AT so it is usable at all times. Phillipa notes this in the review plan and monitors the plan to make sure Ben is making progress to meet his goal.



Practice task 16

1. List two people you can consult with if health goals are not being met.

2. Lisa is a person with complex needs. Recently her mobility has diminished and she is unable to meet her goal of maintaining her own personal care. List two professionals you could seek advice from.

Click to complete Practice task 16