HACC Support/Care Plan Policy and Procedures

1. Purpose

The purpose of this policy is to set out guidelines under which HACC staff can be guided to develop and review Support/Care Plans for clients/carers of the program.

2. Scope

This policy applies to the Accommodation and Community Services Departments of Activ providing support in the following area:

- Home and Community Care

3. Policy Statement

Activ ensures that all clients and carers have a service which is planned, implemented and monitored to meet their identified needs, therefore the development and the review of the Support/Care Plan is instrumental in service delivery. All Activ HACC clients will have an updated and signed Support/Care Plan by the client/carer on their paper file.

4. Definitions

A Support/Care Plan is the outcome of client assessment and reassessment process. It is comprised of goals and strategies that will guide service delivery outcomes that meet the clients identified needs.

Goals contain measurable objectives and are focused on desired client's outcomes to regaining skills, increase level of independence and well being, not merely on attendance at a certain number of activities per week.

5. Principles

5.1. These principles will guide staff procedure in the development and review of a Support/Care Plan.

- Participation of clients, carers, advocate and families in the development and review of Support/Care Plans are fundamental.
- Focus on clients, person centred approach to address clients/cares special needs.
- Focus on the regaining of skills and a subsequent increased level of independence and well being, the wellness approach.
- Proactive in the development of Support/Care Plans looking at future potential for skills development.
- SMART approach to Support/Care Plan ensures that goals are Specific, Measureable, Achievable, Realistic and Time Framed.
- Integration with other relevant plans such as Behaviour Plan, Epilepsy Plan, if applicable.
- Reflect changing needs and or client/carer preference.
- Support/Care Plans should be reviewed after 12 month or earlier if required.

6 Procedures

6.1 Support / Care Plan completed over phone

- If the Support/Care Plan is developed or reviewed over the phone, data entry should be completed on TRACCS (Care Plan tab under tab 4-Intake Details) concurrently using Activ HACC Support/Care Plan template.
- After entry into TRACCS the Support/Care Plan is to be printed and placed in the client paper file.
- Write Support/Care Plan development and next review date on the “Client File Content Page”.
- Post the standard Service Confirmation Letter, with a copy of the new Support/Care Plan to be signed by client and/or carer.
- Signed copy of Service Confirmation Letter to be filed in client’s paper file when received.

6.2 Support/Care Plan completed in clients home

- If the Support/Care Plan is developed or reviewed in conjunction with clients/family/carer in paper format using HACC Support/Care Plan form template on Care Plan tab under tab 4 – Intake details in TRACCS
- Client/Carer signs the Support/Care Plan that has been finalised during visit.
- Complete Support/Care Plan on TRACCS (Care Plan tab under tab 4-Intake Details) when in the office and place a copy of the Support/Care Plan in the client paper file.
- Write Support/Care Plan development and next review date on the Client File Content Page.
- Post the standard Service Confirmation Letter, with a copy of the Support/Care Plan to be signed by client and/or carer.

6.3 Triggers for Support/Care Plan Review

- Communication from client/family regarding changes in client need.
- Feedback from support workers through service delivery observation.
- Scheduled date for Review.

6.4 Client/carer decline copy of the Support/Care Plan

Team Leader conducting the assessment of re-assessment is required to document in the Support/Care Pan and on TRACCS file note section that the client or carer has declined the offer of a copy of the plan.

6.5 Managing dispute between client and carer related to service delivery

HACC Team Leader conducting the assessment or re-assessment is responsible to manage the dispute emphasising the desired outcomes and objectives of the HACC Program.

If the dispute is not resolved, Team Leader should offer and facilitate the involvement of an independent advocate of the client/carer choice or appointed by an Advocacy Agency.

All dispute process should be document on Client File Note and reported to the HACC Team Manager.

7 Reporting

Initial development and review of a Support/Care Plan due to client change of circumstance is reported as Assessment for MDS purpose.

Review of Support/Care Plan due to change of Activity option should report as Client Care Coordination for MDS purpose.

Assessment and Care Coordination activities are only to be recorded in actual time spent with the client in the block of 30 minutes.

For further guidance refer to HACC Program National Minimum Data Set User Guide 1 st January Update 2.01 pg 184, 185.

8 Related Policies and Documents

Assessment and Reassessment Policy

Advocacy Policy

Client File Policy

HACC Support/Care Plan Form

ONI Form

Home and Community Care Service Standards

Carers Charter

HACC Program National Minimum Data

9 Consultation Process

Manager HACC Services

Team Manager HACC Services

Team Leaders HACC Services