Victorian HACC program manual

Part 3: HACC funded activities

About this manual

The *HACC program manual* has three parts.

Part 1: Overview and program management

Part 1 provides an overview of the HACC program, legislative requirements and key Victorian policy and program directions. This part details operational requirements such as the HACC quality framework, employee requirements, funding and reporting, and fees policy overview.

Part 2: Eligibility and access

Part 2 describes the target group, eligibility and priority criteria for the HACC program. It outlines the diversity initiative, the HACC program's approach to assessment and care planning within the service coordination framework.
As HACC is one of a number of government funded programs that clients might need to access, this part includes information about interfaces with other programs and the protocols or arrangements that apply.

Part 3: HACC funded activities

Part 3 provides comprehensive information about the services or funded activities provided by the HACC program. This part starts with a description of the active service model and how it applies across all HACC funded activities.

The description for each activity is structured to include: the scope of the activity, details of how the activity is implemented in practice, staffing and reporting requirements. Links and references are included to other key policy documents or websites.

Part 3: HACC funded activities
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Terminology

The HACC target population is defined in the HACC Review Agreement (2007) as 'older and frail people with moderate, severe or profound disabilities and younger people with moderate, severe or profound disabilities, and their unpaid carers'.

The term 'person' is generally used throughout this document in preference to the term service user, client or consumer. Person means the person receiving the service. In HACC this refers to 'older and frail people with moderate, severe or profound disabilities, younger people with moderate, severe or profound disabilities, and their unpaid carers'.

The term 'carer' refers to unpaid carers such as relatives, friends, neighbours or community members who look after the person. Some people may not have a carer while others may have many carers.

The term 'person and their carer' is used when describing processes that require the active input of both the person and their carer, such as access, assessment, care planning, service delivery and review.

As a general rule the term 'organisation' is used in preference to the term agency. Agency is used where it is included in the name of a document, such as 'agency diversity plan', or when it is used in a direct quotation.

Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander.

The Victorian approach to care: the active service model

Introduction

The Victorian HACC active service model is a quality improvement initiative that explicitly focuses on implementing person and family-centred care, wellness promotion, capacity building and restorative care in service delivery.

The goal of the active service model is for people in the HACC target group to live in the community independently, actively and autonomously for as long as possible. In this context, independence refers to the people's capacity to manage activities of their daily life. Autonomy refers to making decisions about one's life.

This initiative aims to ensure that people attain the greatest level of independence they can and are actively involved in making decisions about their life. This includes understanding their goals, their decisions about the type of services they wish to receive and the desired outcomes.

A useful way to think about an active service model approach is the change from 'doing for' to 'doing with' people. The active service approach is relevant to all people receiving HACC services, from those who benefit from short-term early intervention to those with more complex needs who will require some level of continuing support.

The following elements are important within an active service model approach:

- promoting a 'wellness' or 'active ageing' approach that emphasises optimal physical and mental health and acknowledges the importance of social connections to maintaining wellness
- a holistic and family-centred approach to care
- actively involving people in identifying their desired outcomes and/or setting goals and making decisions about their care
- providing timely and flexible service provision to support people to reach their goals.

This approach requires a broad coalition of service providers taking responsibility and working together with people so that they can retain or improve their independence and/or autonomy.

HACC funded organisations need to ensure that this active service model approach is evident in every contact they have with people.

Principles

The principles of the active service model are:

- People want to remain autonomous.
- People have potential to improve their capacity.
- People's needs should be viewed in a holistic way.
- HACC services should be organised around the person and family or carer. The person should not be slotted into existing services.
- A person's needs are best met where there are strong partnerships and collaborative working relationships between the person, their carers and family, support workers and service providers.

Key components

In translating these principles into practice, service providers should consider the following processes and practices.

Service delivery

Goal directed care and person- and family-centred care

Person-centred assessment is based on how a person defines their strengths, needs, goals and desired outcomes. This is central to all assessments including Living at home assessments for individual HACC services, planned activity groups and other services.

Every person should have a documented care plan based on what is most important to them. Strengths, needs and goals are all included in this plan.

Care planning should consider:

- functional, social and emotional needs, as well as opportunities for meaningful social participation, social connectedness and life enjoyment
- carers and significant others by including and supporting care relationships
- progress towards goals is systematically monitored, with regular reviews
- advice and referral to a range of services and activities within and external to HACC.

Capacity building and the restorative approach to service delivery

- The 'lens' or focus is on maximising the person's independence even if this is only in a small way.
- An enabling approach of 'doing with' rather than 'doing for' which is driven by each person's goals and aspirations.
- Interventions are focused on the person's functional and social goals.
- Participation in health-promoting activities
- Links with social activities are based on each person's interests.
- Opportunities for physical activity are identified.

Flexible and timely responses tailored to the individual

The active service model provides an individualised rather than 'one size fits all' service approach.

The care plan considers whether the person's goals would best be met by time-limited or episodic care rather than open-ended provision of the same service.

A range and variety of service options including:

- timely provision of aids and equipment
- creative and problem-solving approaches to service delivery
- hours of service provision that are flexible and informed by people's needs. For example, services such as community and district nursing and respite may be required during evenings or on weekends or public holidays
- choice and continuity of staff over time which develops trusting relationships, particularly for personal care and domestic assistance
- community care workers and staff members are well matched with the person, taking into account the person's diversity and preferences

- exit from the HACC program is planned with the person and their carer according to progress towards goals or when transition to alternative programs is required
- people who exit the program are confident that they can access HACC services if required again in the future.

Collaborative partnerships between individuals and providers and between providers for the benefit of individuals

Service provider staff including community care workers participate in care plan implementation, monitoring and review processes.

The objective of these collaborative partnerships is to provide:

- coordinated, goal-focused planning between agencies, with processes in place to support this
- access to, and use of interagency case conferencing, joint assessments and secondary consultations
- better and timely access to allied health services
- feedback processes between all people working with a person
- information so that referring providers understand the active service model and can set appropriate expectations with the person.

At an organisation level

Organisation management and leadership to support change

Management:

- is engaged
- leads and participates in the change.

Staff are:

- engaged
- accountable
- involved in the change process.

Workforce development and staff education

The active service model is embedded in:

- recruitment, employment, orientation and induction practices, such as position descriptions and performance reviews
- organisational policy and procedures
- staff training and education programs.

When needed, staff should be able to access:

- skilled and knowledgeable staff with expertise, regardless of where the staff member is based
- multidisciplinary support and use of an interdisciplinary team approach
- time and support for case review and reflection and other professional development strategies
- supervision and support practices that reflect and enhance the active service model
- a culture of reflective practice.

Changing the conversation and communication

- Communication with the person from the point of intake onwards reflects that HACC services are person-centred and will change according to their needs through a process of ongoing review.
- Communications material, promotional materials, advertisements, and websites reflect the active service model.

Staffing statement

For information in relation to qualifications refer to Part 1: 'Employee and related requirements'.

Position descriptions and performance management documentation should include reference to the active service model's person-centred approach.

Links

Active service model resources
http://www.health.vic.gov.au/hacc/projects/index.htm

Framework for assessment in the Home and Community Care program in Victoria (Department of Human Services 2007) http://www.health.vic.gov.au/hacc/downloads/pdf/framework.pdf

Strengthening assessment and care planning: a guide for HACC assessment services in Victoria (Department of Health 2010)
http://www.health.vic.gov.au/hacc/downloads/pdf/assess_guide.pdf

Strengthening assessment and care planning: Dementia practice guidelines for HACC assessment services (Department of Health 2012)
http://www.health.vic.gov.au/hacc/assessment.htm#download

HACC active service model communications toolkit
http://www.health.vic.gov.au/hacc/projects/index.htm

Victorian service coordination practice manual (Primary Care Partnerships Victoria 2012)
http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

Living at home assessment

Introduction

This section describes the requirements for HACC funded Living at home assessments. It is based on the *Framework for assessment in the HACC program in Victoria*, which identifies assessment as a building block for active service model implementation.

The *Framework for assessment in the HACC program* is essential reading for HACC assessment service providers.

Readers should also refer to the sections:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 2: 'Service coordination, assessment and care planning'.

A Living at home assessment is a funded HACC activity delivered by designated HACC assessment services.

The purpose of a Living at home assessment is to gain a broad understanding of a person and their carer's needs, in order to assist the person to live at home as independently as possible.

This involves careful care planning, matching the person's needs and goals to the most appropriate service response either from carers, family members and friends, local community groups and/or subsidised services funded through the HACC program or other health and community services.

There are 99 designated HACC assessment services in Victoria. HACC assessment services comprise 73 local governments, 18 community health and health services, with the remainder being district nursing, bush nursing and other non-government community service organisations.

A number of resources have been developed to assist HACC assessors to develop consistency in their understanding of the concepts, skills and thinking behind Living at home assessments.

HACC assessors should use the following resources in their day-to-day practice:

- *Strengthening assessment and care planning: a guide for HACC assessment services in Victoria* (Department of Health 2010)
- *Strengthening assessment and care planning: workbook* (Department of Health 2010)
- *Induction resource for HACC assessment services* (Municipal Association of Victoria 2010)
- *Strengthening assessment and care planning: dementia practice guidelines for HACC assessment services* (Department of Health 2012)
- *A guide to services for people with dementia and their carers* (Department of Health 2012).

Scope

HACC Living at home assessments are provided by HACC assessment services. A Living at home assessment includes:

- initial contact and initial needs identification
- a face-to-face, holistic assessment with the person, carer and family members, usually in their own home, which:
  - builds on the person's strengths, goals and aspirations
  - identifies opportunities for improving functional capacity and participation in social and community activities
  - includes risk management
- service-specific assessments for services provided by the assessing organisation including the identification of occupational health and safety issues for these services and a fees assessment
- goal directed care planning including a care plan summarising the goals and actions from the holistic assessment and a service plan for services provided by the assessing organisation
- care coordination for people receiving services from multiple agencies.

Assessment for personal care

An assessment for personal care can only be undertaken by staff with adequate skills and training.

If the person's health is unstable and/or if they have complex care needs, the personal care assessment is undertaken by a registered nurse (formerly a division 1 nurse), or other relevant health professional. For more information, see Part 3: 'Personal Care Policy'.

Who is eligible for a Living at home assessment?

Any organisation can refer to a HACC assessment service if they believe the person has broader and more complex needs than can be addressed through their organisation. People and their family or carers can also self-refer.

Organisations referring to a HACC assessment service for a Living at home assessment should provide as much information as possible in the referral to reduce duplication of information gathering.

Fees assessment

All people receiving HACC services must be informed about the HACC Fees Policy. A fees assessment is part of the service-specific component of a Living at home assessment.

HACC assessment services do not charge a fee for the Living at home assessment, as this is a free service. For more information refer to Part 1: 'Fees Policy'.

Exclusions

The Living at home assessment activity includes the provision of care coordination but does not include case management. The Linkages activity is the only HACC activity that provides case management. See Part 3: 'Linkages'.

Assessment

In the context of the active service model, a Living at home assessment is critical to assisting people maintain or improve their health, wellbeing and independence.

A Living at home assessment is based on the following principles:

- person-centred practice
- carer and family focus
- promoting independence
- work in partnerships
- goal directed care planning and service delivery
- system-focused approach.

A Living at home assessment is a process not a one-off event. It includes assessment, care planning, review, reassessment and exit.

The assessment begins with a focus on the person's presenting and underlying needs.

Assessments typically cover:

- general health including nutritional risk
- diversity and cultural requirements
- domestic and personal activities of daily living
- mobility and falls prevention
- cognitive function
- carer and family needs
- environmental risk and personal emergency planning including meeting obligations under the Vulnerable People in Emergencies Policy 2012
- social, emotional and psychological wellbeing
- capacity for functional improvement and self-management.

For further information on assessment domains, and practice skills for Living at home assessments see *Strengthening assessment and care planning: a guide for HACC assessment services* (Department of Health 2010).

Relevant sections in the *Service agreement information kit* include:

- section 4.13: 'Language Services Policy'
- section 4.14: 'Cultural diversity guide', including the *Victorian Government Aboriginal inclusion framework* and *Enabling choice for Aboriginal people with a disability*
- section 4.18: 'Vulnerable People in Emergencies Policy'
- section 4.19: 'Emergency Preparedness Client and Services Policy'.

Care planning

Care planning is a collaborative process with the assessor, the person and their carer. Effective care planning leads to the development of flexible, tailored care options that support the best possible outcomes for the person. Goal directed care planning is empowering, motivating and provides a shared sense of purpose between the person, their carer and service providers.

Care planning resulting from a Living at home assessment includes:

- a holistic care plan documenting the person's priorities, goals and agreed actions resulting from the assessment
- service-specific care plans or service plans for HACC services provided by the assessing organisation
- a referral action plan for referrals to a range of other required services
- information about services or activities such as health promotion and social activities that the person or carer can choose to pursue
- timeframes for review including exit from the HACC program
- assistance with timely transition to more appropriate types or levels of care, such as packaged care or residential aged care.

Care planning needs to be system-focused as well as person-centred. This involves:

- taking account of demands on the organisation's resources and the community care system as a whole
- appropriate targeting of resources and consistency in determining eligibility, priority of access and resource allocation
- suggesting options and alternative sources of support if there is high demand for HACC resources.

For further information on goal directed care planning in Living at home assessments see *Strengthening assessment and care planning: a guide for HACC assessment services* (Department of Health 2010).

Care coordination

In addition to care planning, care coordination is provided for a subgroup of people with complex needs and circumstances. This includes people receiving services from multiple organisations without case management. Care coordination is an extension of the assessment and care planning process, and may include tasks such as:

- facilitating access, care planning and coordination between multiple organisations or services involved with the person, including those outside the HACC program
- facilitating the development and review of the shared care plan
- monitoring and reviewing the progress of the service-specific care plans
- identifying the person responsible for care coordination who may become the key worker.

For further information on care coordination see *Strengthening assessment and care planning: a guide for HACC assessment services* (Department of Health 2010).

Working in partnerships

HACC assessment services are required to work in partnership with key HACC services such as allied health, nursing and access and support workers to achieve a timely and coordinated approach to assessment, reduce duplication and implement the active service model.

Links to other services such as Aged Care Assessment Services (ACAS), disability services and mental health services are also important for coordinated and streamlined care.

Working in partnerships enables and encourages interdisciplinary practices such as:

- secondary consultation
- joint assessments
- case conferences
- shared orientation
- professional development.

Practitioner co-location is also an effective way to promote interdisciplinary practice.

The G*uidelines for streamlining pathways between ACAS and HACC assessment* (Department of Health 2011) describes referral pathways and opportunities for collaboration designed to ensure that frail older people get the right assessment at the right time.

See also:

- Part 3: 'Access and support'
- Part 2: 'Interface programs'
- Part 2: 'Diversity'.

Assessment alliances

In order to work effectively with other organisations and take a lead role in using the active service model, HACC assessment services should develop and work within regional or subregional assessment alliances.

For more information refer to the *Framework for assessment in the HACC program* (Department of Human Services 2007).

Staffing statement

Staff employed to undertake Living at home assessments are expected to have relevant skills and qualifications. The HACC assessment framework requires HACC assessment services transition to assessment staff with relevant higher education qualifications.

Since the composition and names of qualifications change over time and a wide variety of courses are available, the following list is generic. In some cases the registered occupation is listed.

Examples include:

- registered nurse (formerly division 1 nurse)
- physiotherapist
- occupational therapist
- dietitian
- qualifications recognised by the Australian Association of Social Workers
- psychology
- counselling
- disability studies
- health sciences (practice oriented, not population-health oriented)
- Vocational Graduate Certificate in Community Service Practice (Client assessment and case management).

Examples of relevant postgraduate diplomas, certificates and masters degrees include:

- disability studies
- aged care
- counselling
- case management
- complex care
- health promotion
- social work in health settings
- social work in mental health
- community health nursing.

For more information see Part 1: 'Employee and related requirements'.

Reporting requirements

Organisations funded for HACC assessment are required to participate in the quarterly collection of the HACC minimum data set (MDS).

The reporting requirements are found in Part 1: 'Reporting and data collection'.

The HACC MDS is used to record details of individual clients who receive a Living at home assessment, including hours of assessment and care coordination.

- Assessment and care planning should be reported in hours/minutes against the assessment data item in the HACC MDS.
- Care coordination should be reported in hours/minutes in the HACC MDS under the care coordination data item.

For details see *MDS counting rules for HACC assessment services*: *update* (Department of Health 2013).

Links

Framework for assessment in the Home and Community Care Program in Victoria (Department of Human Services 2007)
http://www.health.vic.gov.au/hacc/downloads/pdf/framework.pdf

Strengthening assessment and care planning: a guide for HACC assessment services in Victoria (Department of Health 2010) http://www.health.vic.gov.au/hacc/downloads/pdf/assess_guide.pdf

Strengthening assessment and care planning: dementia practice guidelines for HACC assessment services (Department of Health 2012)
http://www.health.vic.gov.au/hacc/assessment.htm#download

Goal Directed Care Planning Toolkit: Practical strategies to support effective goal setting and care planning with HACC clients
http://www.iepcp.org.au/active-service-model-emr-hacc-alliance

MDS counting rules for HACC assessment services: *update* (Department of Health 2013)
http://www.health.vic.gov.au/hacc/assessment.htm

Guidelines for streamlining pathways between ACAS and HACC assessment services: improving the client journey (Department of Health 2011)
http://www.health.vic.gov.au/agedcare/downloads/pdf/acas_has_guidelines.pdf

Carers Recognition Act 2012 (Victoria) and the *Victorian Charter Supporting Care Relationships.*
http://www.dhs.vic.gov.au/carersact

Vulnerable People in Emergencies Policy (2012)
http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement/4.departmental-policies-procedures-and-initiatives/4.18-vulnerable-people-in-emergencies

Access and support

Introduction

This section describes the requirements for the HACC funded access and support activity. Readers should also refer to:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 2: 'Service coordination, assessment and care planning'
- Part 2: 'Diversity'.

Access and support sits under the banner of HACC diversity planning and practice.

Diversity planning and practice includes consideration of the HACC five special needs groups and the characteristics within and across these groups. Diversity planning and practice also addresses other characteristics that may be a barrier to accessing services such as age, socioeconomic status, gender, faith, spirituality and those who identify as gay, lesbian, bisexual, transgender or intersex (GLBTI).

The objective of the HACC access and support activity is to improve access to a wide range of HACC (and related services) for people who have difficulty accessing services due to their diversity.

To receive access and support services, people must be HACC eligible and have:

- relatively low care needs and experience barriers to access due to their diversity, or
- high care needs and experience access difficulties due to their diversity.

Access and support roles

Access and support roles assist people with complex needs due to diversity to access services that will improve their capacity to live in the community as independently as possible.

The focus of this role is to facilitate access to a wide range of services based on the person's expressed goals, wishes and needs.

Within this context, access and support roles:

- consult and provide information about the range of HACC and other services to targeted diverse communities and the individuals within them
- provide short-term, episodic support to HACC-eligible people who need HACC and other services at key stages of their care pathway
- use strategies to empower and build the confidence of HACC-eligible clients and their carers to access and use services
- work collaboratively with service providers to facilitate improved access to services and support for people with diverse needs
- promote better practice in HACC service delivery responses to meet the needs of diverse communities and the individuals within them.

Diversity alone, without access barriers as a result of diversity, does not confer automatic priority to access and support assistance.

It is important to note that the access and support role is not a case management role or an interpreter service. The role is supplementary to the services provided by the generic agency. The role does not provide broader or systemic advocacy as the focus is on direct case work and support.

Access and support roles:

- provide support to HACC-eligible people who lack the knowledge or confidence to access HACC and other services, or are concerned that the service response will not meet their diverse needs
- work in partnership with the person and their carer and other relevant service providers for an average of eight weeks during the care pathway stages of initial contact, initial needs identification, assessment and care planning (including care reviews as relevant)
- conduct initial contact, commence the initial needs identification process and develop action plans to link people to relevant services. These action plans:
  - list strategies to support the person, for example, by discussing how services work and the scope of service provision
  - facilitate assessment visits and inform assessors about cultural needs or other sensitivities
  - support the person and their carer as active partners in the assessment, decision making process, goal setting and care planning processes
- use support strategies to build confidence and empower the person and their carer to communicate clearly and assertively with relevant service providers and express their own needs
- work within the context of the Agency Diversity Plan and its goals.

Staffing statement

People performing access and support roles must hold the relevant qualifications and experience as noted in the generic job description provided by the Department of Health in April 2011.

Reporting requirements

Organisations funded for access and support are required to submit three reports:

- HACC minimum data set (MDS) data, quarterly
- an access and support activity report to the regional PASA, quarterly
- an implementation report in May annually.

The HACC MDS records the time spent assisting each individual client.
Counting rules are described in the documentation listed below.

Links

HACC diversity planning and practice
http://www.health.vic.gov.au/hacc/projects/diversity_framework.htm

HACC assessment framework
http://www.health.vic.gov.au/hacc/assessment.htm

MDS counting rules for the HACC access and support activity
http://www.health.vic.gov.au/hacc/projects/diversity_advisor.htm

Reporting requirements for the HACC access and support activity
http://www.health.vic.gov.au/hacc/projects/diversity_advisor.htm

Nursing

Introduction

This section describes the requirements for HACC funded nursing.

See also:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 3: 'Personal Care Policy'
- Part 2: 'Service coordination, assessment and care planning'.

Nursing services work with people and their carers to provide clinical expertise, care and treatment, education, advice and supervision designed to:

- improve people's capacity to independently manage everyday activities
- manage chronic disease
- attain or maintain good health, mobility, and safety at home.

Applying clinical judgement and taking into account the person or carer's abilities and goals, nursing services work in partnership with the person, carer/s and other service providers, to progressively restore, improve maintain or sustain the person's health, symptom management, self-management capacity and independence.

Scope

HACC nursing services include:

- nursing assessments
- developing, implementing and monitoring nursing care plans
- providing health management education and information
- monitoring the person's health status
- supporting carers and the care relationship
- personal care for people with unstable health and/or complex needs
- clinical nursing assessments, including supervision and training of other organisations that provide personal care, in accordance with the HACC Personal Care Policy
- supervision and training of nurses, health aides and community care workers who provide personal care
- coordinating nursing and health services with other service providers.

Within this scope, nursing services:
- support the continued ability and independence of the person by encouraging them to do as much as possible for themselves and attain their optimum level of health and independence
- are delivered in combination with other HACC services so that care is an integrated package of services to optimise the person's health and independence
- may be provided at home, in disability supported accommodation, SRS, in a community venue or in a clinic
- aim to ensure that an appropriate level of service is available at the time and frequency indicated by the person's clinical assessment. This may include provision of district nursing after-hours and on weekends
- increase, decrease or cease according to each person's needs.

Exclusions

HACC nursing does not include services provided by a person with nursing qualifications employed in a non-nursing capacity. For example, a planned activity group coordinator with a nursing qualification would not provide nursing care to planned activity group participants.

Assessment and care planning

Nursing commences with an assessment of the person's strengths, capacities, needs and goals. In collaboration with the person and/or carer, a care plan is then developed and documented.

The care plan:

- lists the person's overall goals
- describes how it will assist the person to enhance their health and independence
- describes the agreed nursing strategies and interventions to achieve the person's goals. This includes descriptions of the agreed strategies and timeframes to achieve the person's goals, as well as review dates.

Nursing strategies and interventions include:

- clinical care and treatment
- self-management education
- advice on specific aids and equipment (for example continence aids)
- referral to other relevant services.

Nursing services work closely with personal care services whereby nurses provide the clinical nursing assessment, as well as training and supervision of community care workers who deliver personal care to people with unstable health needs. For more information see Part 3: 'Personal Care Policy'.

Sharing information in relation to the person's care and treatment goals, with other relevant health and HACC service providers, in particular HACC assessment services is critical to the implementation of an active service approach.

HACC nursing services work in partnership with other service providers so that the nursing care plan is part of a coordinated package of services. This may include joint assessments, routine information sharing about care plans and progress, case conferences, secondary consultation, shared care arrangements, and care coordination.

Wound management consumables

Over the past decade new technology in wound dressings and compression therapy has been shown to produce better results and require less health intervention.

Since 2009 –10 the HACC funded nursing activity has included a block funded component to enhance access to these more expensive wound management consumables.

Allocated amounts are based on a formula applied on a recurrent basis to an organisation's nursing HACC activity budget.

This allocation supplements the nursing unit price in order to meet the needs of people who require these more expensive high-technology dressings.

The Wound Management Consumable Subsidy provides an additional contribution to meet costs for people with chronic and complex wounds who do not have capacity to pay for their dressings.

In 2013–14 a top up of the wound consumables allocation will be made to enhance access to wound consumables for people with wounds being managed by either their district nurse or podiatrist.

Guidelines for access to the wound consumables funds will be developed in 2014.

Staffing statement

Role description

HACC nursing may be provided by a registered nurse (division 1) or enrolled nurse (division 2) in a variety of settings. For example, in a person's home, community centre, bush nursing centre or community setting.

The provision of care to people with an unstable health status and/or complex care needs requires the skills of a registered nurse or general practitioner.

Enrolled nurses may provide care to such clients provided a clinical assessment, review and care planning from a registered nurse or other relevant health professional, such as a medical practitioner when appropriate, has been undertaken.

A registered nurse may undertake personal care assessments to determine the appropriate type of staff to provide the personal care for example, community care worker, enrolled nurse, registered nurse. For further information and the specific requirements that apply, see Part 3: 'Personal Care Policy'.

A registered nurse may provide training and supervision to a community care worker in order for them to provide personal care. This might include monitoring or assistance with medication, to a specific person with complex needs or unstable health. For further information and the specific requirements that apply, see Part 3: 'Personal Care Policy'.

Nursing services can employ nurses as consultants with expertise in a range of specialties including, but not limited to, continence, dementia, wound management and pain management.

The nurse consultant may provide both direct clinical care to clients with complex care needs, and build workforce capacity through the provision of mentoring, secondary consultation and education and training. They may also be involved in supporting research activities being undertaken by the service provider.

HACC funded organisations receiving HACC nursing unit price funding are able to use this funding to employ a mix of registered nurses and enrolled nurses to better meet the needs of HACC clients where the following criteria are met:

• The enrolled nurse works within accepted professional scope of practice guidelines and requirements in accordance with relevant national and jurisdictional frameworks and regulations as they apply.

• The enrolled nurse is provided with appropriate supervision in accordance with the above point.

HACC nursing organisations must have appropriate policies and procedures in place to support ongoing competency training and education requirements for registered and enrolled nurses.

Registration, qualifications and scope of practice

Registered nurses and enrolled nurses are part of the national registration scheme for health professionals and must comply with the registration requirements as specified by the Australian Health Practitioner Regulation Agency and those of the Nursing and Midwifery Board of Australia (NMBA).

Under the national registration scheme, enrolled nurses have authority to administer medicines, unless their registration states they are not qualified to undertake this practice.

Registered and enrolled nurses are guided by the NMBA's comprehensive professional practice framework. The framework includes:

- competency standards
- recency of practice and continuing professional development standards
- a code of ethics and scope of practice decision-making framework.

Reporting requirements

Organisations funded for HACC nursing are required to participate in the quarterly collection of the HACC minimum data set (MDS).

For more information see Part 1: 'Reporting and data collection'.

HACC nursing: unit price and targets

Hours of both registered nursing and enrolled nursing should be recorded as hours of nursing for the purposes of the HACC Minimum Data Set. Both count towards the nursing targets in a provider's service agreement.

Nurse consultant hours

A subcategory of HACC nursing is nurse consultant hours. The former continence nursing and wound nurse consultant categories are now included here. Nurse consultant hours will be reported in two ways:

- hours of direct care, if any, provided to clients will be reported through the MDS
- hours focused on building workforce capacity and research will be reported through the annual service activity report.

After-hours nursing

After-hours nursing is block funded. Currently the region and provider negotiate an appropriate unit price on the basis of which targets are identified. These targets are added to the rest of the organisation's nursing target. Funds for after-hours nursing may be negotiated where a nursing provider is undertaking direct service delivery in the evenings, especially activity related to medication management and people with complex needs.

If the nursing service and the department's regional office agree that the service delivery profile should include some after-hours service delivery (not overnight in this sub-activity) an agreed proportion of fund can be transferred into block funding for the after-hours nursing. The regional office and organisation would negotiate a corresponding unit price and a target in hours. This target is added to the unit priced generic nursing target. The aggregated target is used in monitoring the organisation's performance on nursing.

Links

Statewide Equipment Program (SWEP) http://swep.bhs.org.au/

Australian Health Practitioner Regulation Agency http://www.ahpra.gov.au/

Nursing and Midwifery Board of Australia http://www.nursingmidwiferyboard.gov.au/

Allied health

Introduction

This section describes the requirements for HACC funded allied health. Readers should also refer to:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 2: 'Service coordination, assessment and care planning'.

Allied health services provide clinical expertise, care and treatment, education, advice and supervision to improve people's capacity to:

- independently manage everyday activities
- manage chronic disease
- attain or maintain good health, nutrition, mobility and safety at home and in the community.

Allied health services are important in the implementation of the active service model and integrated chronic disease management.

Scope

HACC allied health includes services provided by the following allied health professions (and in certain circumstances by allied health assistants):

- podiatry
- physiotherapy
- occupational therapy
- speech pathology
- dietetics
- counselling from a qualified social worker or psychologist.

For a description of each allied health profession, refer to the table at the end of this section.

Allied health services focus on restoring, improving, or maintaining people's health and wellbeing through:

- clinical allied health assessment, treatment and therapy
- the provision of health management advice, information and support for self-management
- the development, implementation and monitoring of allied health care plans
- monitoring the person's health status in relation to specific allied health disciplines
- training and supervision of allied health assistants who may, under supervision, provide assistance with allied health programs
- provide training and supervision to a community care worker in order for them to provide assistance with an allied health intervention, for example an exercise or therapy program. For further information and the specific requirements that apply, see Part 3: 'Personal Care Policy'.

Within this scope, HACC funded allied health services:

- support the continued ability and independence of the person by providing treatments and therapies that restore, attain or maintain optimum levels of health, wellbeing and independence
- work in partnership with the person, their carer and other service providers to provide coordinated and integrated care to improve or maintain the person's health, self-management capacity and independence
- may be provided in a variety of venues such as the person's home, which can include disability supported accommodation or an SRS, in a community health service or other community venue
- may be provided during weekdays, evenings and weekends so that an appropriate level of service is available at the time and frequency indicated by each person's clinical assessment; this can include the provision of some services after-hours and/or on weekends
- may be provided to a person or to a group of people, such as during a planned activity group or strength and balance training group.

Assessment and care planning

Allied health intervention commences with an assessment of the person's strengths, capacities, needs and goals.

Some assessments such as occupational therapy assessments will be home-based in order to:

- identify safety concerns and falls risks
- prescribe aids and equipment
- promote skills development including conservation techniques to enhance independence in everyday activities.

Assessment should identify opportunities for early intervention and preventive health care, for example, physiotherapy strength, balance and flexibility training programs to improve and maintain mobility and functional capacity

Where a person has unstable health or complex care needs the relevant allied health professional may need to undertake a personal care assessment to determine if it is appropriate that personal care be provided by a community care worker, enrolled nurse or registered nurse. For further information and the specific requirements that apply, see Part 3: 'Personal Care Policy'.

In collaboration with the person and/or carer, a care plan is developed and documented. The care plan:

- lists the person's overall goals
- details the allied health intervention to be provided
- describes how the care plan will assist the person to enhance their health and independence
- includes descriptions of agreed strategies and timeframes for achievement including review dates.

Sharing information about the person's care and treatment goals with health and HACC service providers, in particular HACC assessment services, is critical to the implementation of the active service model.

Care coordination and shared care planning is provided as needed, for example, for a person with multiple and complex needs receiving support from more than one health practitioner or organisation.

Strategies and interventions to enhance the person's health and independence may include:

- working in multidisciplinary allied health teams (for example within health or community health services)
- providing secondary consultations, case conferences, or joint assessment
- working across the continuum of needs from those requiring early intervention to restore independence or minimise the impact of early-stage chronic disease, to those with more complex and chronic needs and ongoing self-management issues
- capacity building such as self-management education in relation to chronic disease
- providing health promotion, education, and information provision on a one-to-one basis or through group programs such as planned activity groups or strength and balance groups to promote, for example, healthy eating or the benefits of physical activity
- supervision of an allied health assistant or community care worker implementing a specific allied health program or intervention that has been designed by the practitioner to support the person's goals. Where assistance is provided by a community care worker this must be in accordance with the 'Personal Care Policy' see Part 3.

Working in partnerships

Allied health services work in partnership with other health and HACC services, particularly HACC assessment services, nursing services and planned activity groups.

Partnerships ensure a timely and coordinated approach, reduce duplication and support the achievement of the person's goals.

Allied health practitioners are encouraged to work in interdisciplinary teams with HACC assessors, in order to implement interdisciplinary practices such as secondary consultation, joint assessments, case conferences, shared orientation and professional development.

Practitioner co-location has been demonstrated as an effective means of promoting interdisciplinary practice.

A partnership approach between allied health practitioners and nurses maximises clinical expertise and ensures an integrated approach to the person's health and wellbeing.

Likewise, a partnership approach between allied health services and planned activity groups ensures timely clinical expertise and access to advice and assistance in the provision of restorative and capacity building programs for group members.

Staffing statement

National registration system

With the exception of dietitians, social workers and speech pathologists, all health professionals must comply with the registration requirements specified by the Australian Health Practitioner Regulation Agency.

Dietitians must be eligible to participate in the Accredited Practising Dietitian (APD) program, a self-regulated professional program run by the Dietitians Association of Australia (DAA).

Social workers must be eligible for membership of the Australian Association of Social Workers.

Speech pathologists must adhere to the Speech Pathology Australia's requirements for professional self-regulation (PSR).

Allied health assistants

Developments in vocational education, training and job design have led to the expansion of allied health assistant roles for dietetics, occupational therapy, physiotherapy, podiatry and speech pathology.

HACC funded organisations receiving HACC allied health unit price funding for any or all these five allied health services are permitted to use this funding to employ a mix of allied health professionals and allied health assistants that will best meet the needs of HACC clients.

All allied health assistants employed with HACC allied health funding must hold relevant qualifications. Relevant competency units are listed below. As national training packages change over time, any new relevant competency units will be documented on the Victorian HACC website.

HLT07 Health Training Package Version 4

• HLT42507 Certificate IV in Allied Health Assistance

HLT07 Health Training Package Version 5

• HLT42512 Certificate IV in Allied Health Assistance

Allied health assistants must also hold the specialisation competency unit electives for the allied health profession they assist. For example the specialisation electives for physiotherapy must be held for assistance to be given to a physiotherapist.

Allied health assistants must be provided with adequate guidance, supervision and instruction by a designated allied health professional with the relevant allied health qualification. For example a podiatrist must supervise a podiatry allied health assistant.

People using HACC services must receive adequate and appropriate clinical assessment, review and care planning from the relevant allied health professional.

For more information see:

• *Supervision and delegation framework for allied health assistants* (Department of Health 2012)
• *Growing your allied health assistant workforce planning tool* (Department of Health 2012)
• *Supervision and delegation framework for allied health assistant case studies* (Department of Health 2012).

Reporting requirements

Organisations funded for HACC allied health are required to participate in the quarterly collection of the HACC minimum data set (MDS).

For details, see Part 1: 'Reporting and data collection'.

The HACC MDS is used to record individual clients receiving direct and indirect hours of allied health by discipline.

Countable time includes time spent:

- in contact with the client, their family or carers
- writing case notes
- attending case conferences
- monitoring and reviewing plans
- making SCTT referrals
- undertaking care coordination, that is, developing Shared Support Plans, attending inter-agency meetings, assisting people to obtain other necessary services.

Reporting of allied health assistant hours for the purposes of the HACC MDS should be recorded within the hours of the profession they support. For example, the time spent by an occupational therapy assistant should be recorded on the client's record as hours of occupational therapy. These hours will count towards the organisation's target hours of HACC allied health in the service agreement with the Department of Health.

If targets need to be varied, allied health organisations should advise their Program and Service Advisor (PASA) to ensure a shared understanding of the mix of allied health disciplines being provided.

Secondary consultations

Total time spent by an allied health professional on secondary consultations for clients of other HACC organisations can be reported through the MDS. New instructions for how to report secondary consultations will be provided in a *HACC MDS guidelines update* in 2014.

Allied health description

Profession	Description (adapted from the Better Health Channel)
Dietetics	Dietitians assess people's nutritional status and provide food and nutrition information to improve health and wellbeing. Dietitians provide information about modified diets to manage conditions such as malnutrition, dysphagia, diabetes, heart disease, obesity, cancer, food allergies and intolerances. Dietitians assist HACC-eligible people by providing dietary and nutritional advice to assist nutritional wellbeing and thus support independent living.
Physiotherapy	Physiotherapists provide assessment, manual therapies, exercise programs and other techniques to treat a range of conditions. Physiotherapists assist HACC-eligible people with their physical functioning, mobility and capacity to perform the necessary activities of daily life and thus support independent living.
Podiatry	Podiatrists treat foot conditions through prevention, diagnosis, treatment and rehabilitation. Podiatrists assist HACC-eligible people with their personal foot care, mobility and functioning and thus support independent living.
Occupational therapy	Occupational therapists assist people to overcome various limitations in order to live more independent lives. Occupational therapists assist HACC-eligible people with activities of daily living, general functioning, mobility, aids and equipment, and home safety and thus support independent living.
Speech pathology	Speech pathologists work with people who have communication or swallowing difficulties. Speech pathologists use a wide variety of communication and swallowing therapies with HACC-eligible people to enhance their communication and independence and thus support independent living.
Counselling	HACC funded counselling may be provided by social workers or registered psychologists. Counselling assists people to resolve their problems in a positive way by helping to clarify the issues, explore options, develop strategies and increase self-awareness. Examples include grief counselling, support to carers, counselling for depression or other emotional and psychological conditions. Social workers or registered psychologists work with HACC-eligible people to manage their situation and enhance emotional wellbeing and thus support independent living.

Links

Supervision and delegation framework for allied health assistants (Department of Health 2013)
http://www.health.vic.gov.au/workforce/reform/assistant.htm

Resource for providers of HACC and primary health services: how the ASM and ICDM policies align
(Department of Health 2010) http://www.health.vic.gov.au/pch/downloads/hacc_icdm_alignment.pdf

Well for Life http://www.health.vic.gov.au/agedcare/maintaining/wellforlife.htm

Australian Health Practitioner Regulation Agency http://www.ahpra.gov.au/

Community Services and Health Industry Skills Council www.cshisc.com.au

National Training Package information http://training.gov.au

Personal Care Policy

Introduction

This section describes the Personal Care Policy.

Readers should also refer to the following sections:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 3: 'Nursing' and 'allied health'
- Part 2: 'Service coordination, assessment and care planning'.

Personal care describes assistance with self-care tasks such as showering, dressing and mobility and assistance with medication, as well as assistance with other activities of daily living such as shopping, meal preparation and escorting to medical appointments and community activities.

Services work in partnership with the person, their carer and other service providers to progressively improve, maintain and monitor the person's independence and capacity to live safely at home and participate in community activities.

Assistance is provided in a manner which promotes skills development, capacity building and independence.

When this policy applies

This Personal Care Policy applies to both:

- personal care as a discrete HACC funded activity
- situations where personal care is provided as part of another HACC activity, such as:
    - planned activity groups
    - respite care
    - a Linkages package.

All paid staff delivering personal care must have the competencies to do so as evidenced by the attainment of the appropriate competency units listed below.

Scope

Transferable personal care skills

Where a person has stable health, personal care skills are regarded as transferable. This means that skills can be obtained through attaining the relevant personal care and first aid competency units and then applied to a number of people.

Examples of personal care tasks include:

- assistance or supervision with bathing, showering or sponging
- demonstrating and encouraging the use of techniques to improve the person's capacity for self-management or carer support
- building confidence in the use of equipment or aids, such as a bath seat or handheld shower hose
- assistance with dressing and undressing
- assistance with shaving, hair care and grooming

- assistance with mobility such as getting in and out of bed, sitting up, turning, standing and walking, and transfers to commode, wheelchair, chair or vehicle
- assistance with eating, drinking, cooking, preparation and service of food, preparation of special diets and shopping
- assistance with toileting
- monitoring self-medication; this may involve the community care worker observing and reporting to their supervisor, for example, if they notice that medication has not been taken
- taking the person to medical and other related appointments
- accompanying the person to community activities in order to build confidence and access to activities that enhance social inclusion
- building the person's confidence and capacity for community access by assisting the person to:
  - use public or subsidised transport
  - use volunteer support
  - connect or reconnect with community and cultural groups
  - increase confidence and capacity to attend events.

Assistance that requires additional non-transferable skills training

Where a person has unstable health or complex care needs the community care worker is required to have additional education and training specific to that person. These skills are not transferable to other people. In these circumstances, assessment and care planning as well as staff non-transferable skills training and supervision is required by a registered nurse or other relevant health professional.

Some personal care tasks can only be provided following the provision of additional, non-transferable skills training. These include:

- Assistance with prescribed complex exercise or therapy programs. This assistance can only be provided on a person-specific, non-transferable skills basis.

  The allied health professional will develop a goal directed care plan and instruct the community care worker in how to support the person, timeframes for review, and mechanisms for monitoring progress.

  Community Care Workers must not be taught a standard set of exercises or a therapy program to use across the HACC target group as this is outside the scope of a community care worker's role.

- Assistance with an exercise program designed by an allied health professional for a planned activity group session under appropriate professional supervision taking into account the needs of individual participants.
- Fitting and use of appliances such as splints and callipers, or hoists
- Assistance with hearing aids and communication devices.

Assistance that requires completion of specific competency units and non-transferable skills training

Personal care activities that can only be provided following the completion of specific competency units in addition to the relevant personal care and first aid competencies and non-transferable skills training are:

- assistance with medication
- provision of basic foot, skin and nail care
- assistance with oral hygiene.

The relevant competency units are listed below.

Where the community care worker is involved in food handling and meal preparation they must adhere to safe food handling practices including personal hygiene and cleanliness.

Employees should encourage their staff to undertake food handling training. The relevant competency unit is HLTFS207C Follow Basic Food Safety Practices. This is available as an online unit through the HACC Education and Training provider.

Settings

Personal care is provided in a range of locations including the person's home and in a range of community settings, as either a discrete personal care funded activity, or as part of another HACC activity.

Exclusions

Volunteers are not expected to provide personal care. Vocational students may only provide personal care under supervision as part of their completion of the relevant competency units or professional course.

Assessment

The need for personal care is determined following an assessment of each person's strengths, capacities, needs, physical environment and goals, including the availability, needs and wishes of any carers. For most people, personal care needs are assessed as part of a Living at home assessment.

For most people who require assistance with tasks that are not complex, personal care skills are regarded as transferable. That is, skills obtained in the personal care and first aid competency units may be used with many people. Personal care will be provided by a community care worker in most situations.

However some people will have unstable health and/or complex care needs. In these situations it needs to be determined if it is appropriate for a community care worker to provide that assistance or it may be appropriate for personal care to be provided by a registered nurse.

In some circumstances personal care will be provided by an enrolled nurse. Personal care tasks undertaken must be within the scope of practice of the enrolled nurse.

Unstable health and/or complex care needs

For people with unstable health and/or who require assistance with complex care tasks, an assessment must be undertaken by a health professional such as a registered nurse (formerly known as division 1) or other relevant health professional. The assessment will determine if it is appropriate for a community care worker to undertake personal care tasks for the person being assessed. In some situations personal care will be undertaken by a registered nurse (formerly known as division 1) or an enrolled nurse (formerly known as division 2).

Where a community care worker is providing personal care to a person with unstable health or complex needs/tasks non-transferable skills training and supervision will be provided by the registered nurse or other relevant health professional. It is important that this training and the supervision are ongoing and not seen as one-off events. The skills required of community care workers providing personal care to people with unstable health and/or complex needs are regarded as non-transferable, for example skills learned in the context of caring for a particular individual cannot then be used in caring for another person.

Person-specific training is required for every person with unstable health and/or complex needs.

Examples of unstable health

The following list of indicators is used as a guide to determine the existence of unstable health. A single factor does not necessarily indicate unstable health. An assessment for personal care for people with an unstable health status is undertaken by a registered nurse or other relevant health professional. Indicators of unstable health include:

- giddiness/falls
- loss of bladder or bowel control
- acute or chronic diarrhoea/constipation
- acute or chronic nausea/vomiting
- special dietary requirements/limitations, for example percutaneous endoscopic gastrostomy (PEG) feeding regimes
- pain
- difficulty with breathing/advanced respiratory disease
- terminal or life-threatening illness in the palliative care stage
- recent changes in sensory status such as the deterioration of vision or hearing
- apparent fever or persistent excessive coldness
- wounds (surgical/non-surgical)
- persistent bruising and/or skin integrity breakdown
- significant recent changes in medications
- multiple (more than five) and frequent use of medications (three times per day or more)
- several recent hospital or respite admissions
- progressive deteriorating chronic illness
- any procedure requiring insertion into the body (including injections)
- disorientation/confusion/memory loss undiagnosed and/or leading to uncooperative behaviours during personal care
- very limited mobility, for example people who are bed-bound or need assistance with transfers.

Examples of complex care needs

Assessment for personal care for people with complex care needs must be undertaken by a registered nurse or other relevant health professional.

The following is a list of examples of complex care needs and is not exclusive:

- assistance with medication
- provision of basic foot, skin and nail care
- assistance with oral hygiene
- assistance with prescribed complex exercise or therapy programs
- exercise programs for planned activity group sessions
- the fitting and use of appliances such as splints, callipers and hoists
- assistance with hearing aids and communication devices
- people with disabilities or severe health conditions where life-maintaining procedures are managed by family member carers, who require respite (such as PEG feeding and/or suctioning).

Duty of care

It is a general legal standard that people using services have a right to expect that staff who provide nursing or personal care:

- have the necessary skills and knowledge to provide that care
- will take reasonable care to avoid harm and protect them from injury.

All HACC services and their staff members owe a duty of care to people using HACC services and are responsible and independently accountable for their actions at all times.

Therefore, health professionals are obliged to use their professional judgement when deciding whether or not to allocate aspects of a person's personal care to a community care worker or enrolled nurse.

This decision will be made on an individual basis, taking into account relevant legislation, professional codes of conduct, ethics and the policies of professional and registration bodies.

Service provider organisations should support health professionals in this decision making, for example through the provision of training, education, and written protocols.

Health professionals' roles and responsibilities

The personal care assessment, care planning process, non-transferable skills training and supervision processes should include health professionals with appropriate qualifications as relevant to each person.

Appropriate qualifications are:

- medical practitioners
- registered nurses (formerly known as a division 1 nurses)
- allied health professionals including: occupational therapists, physiotherapists, speech pathologists, podiatrists and dieticians
- dentists.

The responsibilities of health professionals include:

- working within the expectations and boundaries of their profession
- keeping up-to-date with particular skills, assessment or care techniques within their area of professional expertise and addressing ongoing training needs
- regular monitoring and review of each person's progress and care plan within their area of professional expertise
- implementing organisation and interagency protocols
- accepting responsibility within their area of expertise for:
  - assessment and care planning
  - non-transferable skills training
  - the supervision of community care workers and enrolled nurses.

Note that information contained in this manual should not conflict with accepted professional roles or responsibilities, or the roles and responsibilities of relevant registration bodies.

For more information see Part 3: 'Nursing and allied health'.

Community care workers' role and responsibilities

Community care workers are part of a broader team working with the person to optimise their health and independence.

Coordinators should ensure community care workers have access to relevant information from the assessment and care planning process to enable an adequate understanding of the person's needs, strengths and goals.

Responsibilities of community care workers involved in the delivery of personal care include:

- working within the parameters of their job as determined by their position descriptions, employment skills, training, local-area work agreement, contract or award
- keeping up-to-date with personal care techniques and addressing their own training needs
- implementing each person's care plan
- developing and maintaining a respectful and comfortable working relationship with the person and their carer, which includes observing appropriate confidentiality and boundaries
- actively observing and reporting each person's progress, wellbeing and any changes in their health status, circumstances or condition.

In some circumstances personal care will be provided by an enrolled nurse. The above points also apply to enrolled nurses. In addition personal care tasks undertaken must be within the scope of practice of the enrolled nurse.

Care planning

Personal care assistance is provided according to a care plan.

Care is provided in a way that:

- builds on the person's care priorities, strengths and capabilities
- offers choice in how the assistance is provided
- encourages the person to participate and undertake as many components of the task as possible
- supports the person and their carer to maintain or improve their capacity to perform personal care tasks
- uses a flexible approach to assist the person to achieve their goals.

Where personal care is required, a person-centred care plan is developed which lists the person's goals, priority tasks for assistance, and how personal care supports will be provided.

Care planning also involves decisions about the appropriate category of staff to provide assistance.

If the person has unstable health or requires assistance with complex care tasks, the service could be provided by a registered nurse, enrolled nurse or community care worker with additional competency and/or non-transferable skills training depending on the assessment outcome.

The care plan needs to be available to all those involved in the care, including the community care worker. The care plan details how and when personal care will be provided, including:

- the specific personal care procedures to be implemented by community care workers and/or enrolled nurses and/or health professionals based on the person's goals and priorities
- any non-transferable training required of the community care worker providing personal care, including details of who will provide the training, and when and how competency will be assessed
- an agreed, documented process for the community care worker to monitor and report on the person's progress towards the goals in their care plan and any changes observed in the person's condition or needs
- monitoring and supervision processes for the community care worker providing the personal care to ensure the care plan is being implemented and the worker has access to support as required
- emergency procedures, telephone numbers, on-call backup people and processes
- nursing, medical, dental or allied health supervision or monitoring required, such as nursing visits at specific intervals
- staff support and accountability
- regular review and reassessment processes with the person and their carer, including timelines measuring progress against goals
- how changes to the care plan will be communicated to person and/or carer.

An occupational therapy assessment is often required where the safety of the environment for the person, their carer or community care worker can be improved through modifications or equipment, and where such assistance improves the person's capacity to become more independent. The coordination of these assessments is usually undertaken by the service providing the Living at home assessment.

A person's need for assistance may change over time because:

- a person's capacity to self-manage has improved
- tasks have become more complex.

If tasks have become more complex a reassessment would be required. Depending on the circumstances, the staff member may require:

- reassurance and support
- skills training specific to that person
- skills training as an additional competency.

Where the person is receiving support from multiple organisations, a shared care plan should be developed in order to provide a coordinated and integrated approach.

In some circumstances an enrolled nurse will provide personal care. In these cases, the above points also apply to enrolled nurses. Personal care tasks undertaken must be within the scope of practice of enrolled nurses.

Allocation and continuity of care

The allocation and continuity of the individual staff member providing personal care should be a priority for service providers.

The decision about who provides and supervises personal care services should occur during the care planning process and should be clearly documented and retained by the service. The decision is made on an individual basis, taking into account the person's needs, characteristics and preferences, and where it is appropriate, their carer/s, as well as the tasks to be performed.

As community care workers (or other staff as noted above) develop a trusting relationship with the person to enhance their confidence and wellbeing, the continuity of care is a key consideration.

There are multiple considerations in identifying and allocating the most appropriate staff member to implement personal care tasks. These include:

- the ability of the person to regain or maintain independence
- the stability of the person's condition, including the nature and level of dependence, and the level of intervention, monitoring and decision making required
- the wishes and diversity characteristics of the person and their carer, including language, cultural and gender preferences
- the level of risk of deterioration in health status, including loss of function or risk of institutionalisation if appropriate services are not provided
- family and social dynamics including the psychological status of the person and any informal carers
- the suitability and safety of the environment, including health and safety issues for the person and paid staff members
- the availability of a suitable community care worker and the urgency of need
- additional individualised or competency-based training requirements
- support and monitoring requirements, accountability, and legal liability.

If a person has unstable health and/or complex needs, all of the above must be considered.

A community care worker who is prepared to be trained in and perform a particular non-transferable skill needs to be selected. A community care worker may refuse to be trained in and undertake a non-transferable skill where they feel uncomfortable doing so.

Transfer of care

If an assessment, care planning or review process identifies that personal care should be transferred to another community care worker, enrolled nurse or another service provider, it is essential that:

- the person's and their carer's wishes are considered in relation to the transfer of service provider responsibilities
- the transfer is coordinated, integrated and well managed so as to avoid any disruption to service provision and achieve a smooth, streamlined transition process
- the incoming service provider receives an appropriate 'hand-over' in the care requirements of the person
- prior to providing personal care to a person with an unstable health status and/or complex needs, the community care worker must receive training by a relevant health professional, such as a registered nurse.

Personal care competencies

As identified above, personal care tasks may be undertaken by:

- a registered nurse (formerly known as a division 1 nurse)
- an enrolled nurse (formerly known as a division 2 nurse)
- a community care worker.

Community care workers undertaking personal care tasks must undertake appropriate registered vocational training before providing any HACC personal care services.

This includes personal care provided through subcontracting arrangements and HACC activities that include personal care, such as planned activity groups, respite care and Linkages packages.

All community care workers who undertake personal care tasks funded by the HACC program must have an appropriate minimum Certificate III level qualification with the relevant personal care and first aid competency units. The relevant competency units are listed below. As national training packages change over time any new relevant competency units will be documented on the Victorian HACC website.

While the competency unit Apply first aid is an elective for Certificate III in Home and Community Care in the CHCO8 Community Service Training Package, it is a requirement of the HACC program that all staff complete Apply first aid, before undertaking personal care tasks.

For occupational health and safety and duty of care requirements it is advisable all community care workers complete this first aid competency unit. Therefore this competency unit should be included as one of the electives completed by community care workers when they undertake the Certificate III in Home and Community Care.

Where a community care worker has completed a qualification without the relevant personal care and/or first aid competency units then they must complete these units before undertaking personal care tasks. The relevant first aid and personal care competency units are:

- CHC08 Community Services Training Package Version 3

  - HLTFA301B Apply first aid — with updates in accordance with the Australian Resuscitation Council Guidelines; or

- CHC08 Community Services Training Package Version 4

  - HLTFA311A Apply first aid — with updates in accordance with the Australian Resuscitation Council Guidelines.

And also:

- CHC02 Community Services Training Package

  - CHCHC302B Provide personal care in a home and community care environment

or

- CHC08 Community Services Training Package Version 3

  - CHCICS301A Provide support to meet personal care needs

or

  - CHCICS401A Facilitate support for personal care needs

or

- CHC08 Community Services Training Package Version 4

  - CHCICS301B Provide support to meet personal care needs

or

  - CHCICS401B Facilitate support for personal care needs.

Medication assistance as part of personal care

Medication assistance may be provided as part of personal care where the community care worker has completed the necessary competency based medication training and non-transferable skills training specific to the person.

Staff undertaking personal care tasks who have not completed this training can only monitor self-medication. Monitoring self-medication consists of a community care worker observing and reporting to their supervisor, for example, if they notice medication has not been taken by the person.

Assisting with medication includes the provision of:

- physical assistance with medication

- supporting people with self-medication in response to assessed need

- collecting prescription medications which can only be undertaken in accordance with this policy, for example following clinical assessment and appropriate training.

Community care workers must have completed the relevant first aid and personal care competency units as listed above and the relevant medication competency units as follows:

- CHC02 Community Services Training Package
    - CHCCS304A Assist with self-medication

or

- CHC08 Community Services Training Package Version 3:
    - HLTAP301B Recognise healthy body systems in a healthcare context; and
    - CHCCS305B Assist clients with medication (note pre-requisite HLTAP301B)

or

- CHC08 Community Services Training Package Version 4:
    - HLTAP301B Recognise healthy body systems in a healthcare context; and
    - CHCCS305C Assist clients with medication (note pre-requisite HLTAP301B).

If a HACC community care worker has not undertaken any medication training they need to attain both units from the CHC08 Community Services Training Package Version 4.

If a HACC community care worker has already attained CHCCS304A Assist with self-medication (from CHC02 Community Services Training Package), it is recommended they complete HLTAP301B Recognise healthy body systems in a healthcare Context from CHC08 Community Services Training Package Version 4. They may also wish to complete CHCCS305C Assist clients with medication.

A Certificate IV unit called CHCCS424B Administer and monitor medications has been included in CHC08 Community Services Training Package Version 4. However, this unit is not required for the HACC community care worker role.

The competency training outlined above will enable community care workers to assist with medication. This assistance must be delivered in accordance with the HACC Personal Care Policy relating to people with unstable health and/or complex care needs. The policy requires:

- assessment by a registered nurse or other relevant health professional
- determination if it is appropriate for a community care worker to assist with medication
- training for the community care worker specific to the needs of the person by a registered nurse or other relevant health professional
- ongoing support for the community care worker from a registered nurse or other relevant health professional
- development and implementation of a written care plan for the person.

People who require self-medication monitoring may also have unstable health and/or complex care needs and therefore require a clinical assessment.

Where a clinical judgement has been made that it is not appropriate for a community care worker to assist with medication, assistance can be provided by a HACC funded nursing service.

No assistance with medication or self-medication should be provided on an ad hoc basis. This includes all forms of prescribed and over the counter medications. Assistance should always be given in accordance with the assessment of the person's needs and the instructions in the written care plan.

Community care workers delivering HACC funded services are not permitted to make clinical judgements. Clinical judgements are the responsibility of clinical professionals such as registered nurses or general practitioners. Community care workers need to have a clear understanding that their role is to provide assistance and/or monitoring only.

Where appropriate the written care plan could include some physical assistance (such as with the use of an inhaler) depending on the outcome of the assessment of the person's care needs.

HACC funded organisations should develop written policies outlining the processes that will take place when a community care worker is assisting with medication or monitoring self-medication as part of a person's written care plan.

As HACC services are provided in the person's own home on a time-limited episodic basis, procedures and policies for monitoring self-medication and assistance with medication are necessarily different to those developed for a residential care setting.

A HACC funded organisation's policy could include:

- material from the HACC Personal Care Policy
- a statement that the person or carer is responsible for their medication regime, and has received professional advice from their general practitioner or a registered nurse
- a statement that the community care worker does not determine the medication dosage or timing but provides assistance or monitoring with the already prepared medication dosage in accordance with the person's written care plan
- a communication procedure outlining who the community care worker should contact if a request is made that is not part of the person's written care plan
- emergency procedures
- procedures for documenting self-medication monitoring and assistance with medication including when medication has been refused, missed or the person is unable to take it
- a statement that community care workers are not to deviate from the instructions given to them by their supervisor and that they are not to take instructions from anyone else unless this has been prearranged as part of the care plan or is an instruction from emergency services personnel.

Foot care as part of personal care

Community care workers can assist with foot care based on appropriate assessment and care planning, provided they have first completed the relevant personal care and first aid competency units and then completed either:

- CHCO8 Community Services Training Package Version 3
  - CHCICS306B Provide basic foot, skin and nail care

or

- CHCO8 Community Services Training Package Version 4
  - CHCICS306B Provide basic foot, skin and nail care.

The above qualifications will enable community care workers to undertake HACC funded foot, skin and nail care as long as this is done in accordance with the HACC Personal Care Policy relating to people with unstable health and/or complex care needs.

As noted in the Descriptor in CHCICS306B this unit describes the knowledge and skills required to provide basic foot skin and foot nail care to people. As noted in the Application Statement this unit may apply to work with older people in a range of residential and community service contexts. This level of support does not involve the professional input from a podiatrist.

HACC allied health funding cannot be used to fund community care workers who hold the required competencies and are providing basic foot skin and foot nail care to people who use HACC services.

Oral hygiene as part of personal care

Community care workers can assist with oral hygiene care, based on appropriate assessment and care planning, provided they have first completed the relevant personal care and first aid competency units and then completed either:

• CHC08 Community Services Version 3 Training Package

  - CHCOHC406A Provide or assist with oral hygiene

or

• CHC08 Community Services Version 4 Training Package

  - CHCOHC406B Provide or Assist with oral hygiene.

This will enable community care workers to undertake HACC assistance with oral hygiene as long as this is done in accordance with the HACC Personal Care Policy relating to people with unstable health and/or complex needs.

Non-transferable skills training

Where a health professional is delegating personal care activities to a community care worker and the person receiving the service has unstable health and/or complex needs, it is important that the community care worker is given person-specific training in the personal care to be provided. Training will be relevant only to that person, in that situation. Skills learned are not transferable to other people receiving personal care. In other words, the community care worker is not considered competent to undertake these personal care procedures with other people receiving personal care.

Where non-transferable skills training is required the following must be adhered to:

• training must be provided by a registered nurse (formerly division 1), and if necessary other qualified health professionals with expertise relevant to the area, and who are employed in that capacity

• training required, personal care procedures and monitoring and supervision regime for the service recipient and the community care worker must be documented in the care plan and provided by a registered nurse and if necessary other relevant health professional

• training must be provided in the context of passing on information about caring for that specific service recipient

• the community care worker must have the relevant competency units

• the community care worker must be employed at a skill level commensurate with the tasks.

In some circumstances an enrolled nurse will provide personal care. The above also applies to enrolled nurses. Personal care tasks undertaken must be within the scope of practice of the enrolled nurse.

In-service training

Organisations providing personal care should employ staff who have the appropriate competency units and should provide regular and appropriate in-service or refresher training for staff, for example personal care refresher manual skills training. Staff training needs assessment should also be undertaken to determine future training needs.

Staffing statement

All community care workers who undertake personal care tasks funded by the HACC program must have an appropriate minimum Certificate III level qualification with the relevant personal care and first aid competency units.

Where a community care worker holds a qualification not listed in the 'Employee and related requirements' in Part 1, or they have completed a qualification without the relevant personal care and first aid competency units, whether the qualification is listed or not, they must complete these units before undertaking personal care tasks.

Community care workers must have completed competency-based medication training before assisting with medication. Staff who have not completed this training and who are undertaking personal care tasks can only monitor self-medication and may not assist with medication.

Community care workers can only provide personal care to people with unstable health and/or complex care needs if they have received additional training specific to that person.

The remuneration and classification of community care workers delivering personal care should recognise the level of skill and knowledge required to provide personal care services.

Reporting requirements

Organisations funded for HACC personal care are required to participate in the quarterly collection of the HACC minimum data set (MDS).

For details, see Part 1: 'Reporting and data collection'.

The HACC MDS is used to record details of individual clients receiving hours of personal care.

Links

Community Services and Industry Skills Council
www.cshisc.com.au

National Training Package Information
http://training.gov.au

Domestic assistance

Introduction

This section describes the requirements for HACC funded domestic assistance.
Readers should also refer to:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 3: 'Living at home assessments'
- Part 3: 'Personal Care Policy'
- Part 2: 'Assessment and care planning'.

Domestic assistance provides advice and assistance to improve or maintain people's capacity
to manage everyday activities in a safe, secure and healthy home environment.

Scope

Examples of domestic assistance tasks include:

- skill development and capacity building, for example, demonstrating the use of light-weight
  cleaning equipment
- teaching the person unfamiliar tasks or techniques to resume tasks such as meal preparation
  so they can manage as independently as possible
- essential cleaning in the bathroom, toilet, kitchen, laundry, living area and bedroom,
  such as dishwashing, mopping or vacuuming floors, dusting, changing bed linen,
  clothes washing and cleaning bench tops, stove tops or refrigerators
- working alongside and sharing tasks with the person in order to build their confidence
  and maintain their capacity to do as much as possible for themselves
- doing shopping and running small errands
- escorting the person to do their shopping, pay bills or attend medical and related appointments
  where no personal care is required; note that HACC service providers do not give financial advice
  or offer to assist with managing a person's finances
- preparing meals (see the 'Staffing statement' below)
- escorting the person to a physical activity program to improve their strength, capacity
  and confidence where no personal care assistance is required
- maintenance of the home and garden to ensure there are no health or safety risks
  (see also the 'Property maintenance' section of this manual)
- organising one-off rubbish removal, spring cleaning and household organisation to improve safety
  and household management
- assisting with pet care when family, neighbourhood or volunteer-based community assistance
  is not available or appropriate.

Domestic assistance or personal care

The assessment process should include consideration of whether the specific support required comes under domestic assistance or personal care.

It is appropriate for the assistance to be provided as personal care if:

- The person requires physical assistance with activities such as meal preparation, mobility or toileting.
- The care plan is designed around regaining skills.

Some of the tasks described above may require input from an allied health professional such as an occupational therapist or physiotherapist as part of the care plan development.

For more information see 'Allied health' and 'Personal Care Policy' sections, both in Part 3.

Assessment and care planning

Domestic assistance commences with a face-to-face assessment to explore needs and issues relevant to activities of daily living and maintaining the home environment. This may occur as a service-specific assessment or as part of a Living at home assessment.

Assessment includes:

- discussion about the person's strengths, capabilities, interests and underlying need for support
- identification of tasks that the person is able, unable or partially able to do
- identifying opportunities for building skills and confidence in undertaking tasks
- consideration of allied health intervention to improve the person's capacity to do certain tasks for themselves including the use of aids and equipment
- occupational health and safety assessment including assessment of cleaning processes and equipment
- identification of safety concerns to prevent falls or other accidents
- personal safety during emergencies and extreme weather events such as heatwaves.

Following assessment, a goal directed care plan is developed in collaboration with the person and their carer. The plan takes into account the person's abilities and priorities. It also lists the person's goals and strategies to maximise their independence at home, including:

- agreement on tasks that will be undertaken by the person, their carer, other family members and the community care worker
- provision of support in a manner that supports incidental physical activity
- referrals as needed for allied health, aids and equipment or other assistance to build skills and confidence
- timeframes for the assistance to be provided for example, single episode, short term, ongoing, periodic or intermittent
- an occupational health and safety plan
- provision of information on independence at home and safety issues such as information on personal emergency planning, smoke alarms and how to cope in a heat wave
- assistance with transition or exit as relevant.

The care plan provides instructions to community care workers in terms of the person's goals and the tasks and supports to be provided.

Each person's progress is monitored and there is a clear process for community care workers to report observed changes in the person's condition. Care plans and progress towards goals are reviewed on a regular basis.

For further information on occupational health and safety see Part 1 'Employee and related requirements'.

Role of community care worker

Assessment staff, team leaders and supervisors should provide community care workers, including casual staff with access to relevant information about the person's needs, strengths and goals from the assessment and care planning process. This will assist community care workers to:

• understand their role and the specific tasks to be undertaken as identified in the care plan

• understand their role in demonstrating, coaching, supervising, and/or mentoring clients to achieve their goals

• participate as part of a broader team in optimising people's health and wellbeing

• observe and monitor the person and their carer's progress and provide feedback.

As community care workers develop trusting relationships with a person, the continuity of care becomes a key consideration.

Matching the community care worker to the person's needs should be considered during the care planning process. The matching process must take into account:

• the person's needs, diversity characteristics and preferences

• where appropriate their carer/s needs, diversity characteristics and preferences

• the tasks to be performed.

Staffing statement

For detailed information on the qualifications required, refer to Part 1 'Employee and related requirements'.

Organisations providing domestic assistance must have appropriate policies and procedures in place to:

• ensure appropriate time is allocated for support and supervision of community care workers

• support the ongoing competency training and education requirements for community care workers.

Where the community care worker is involved in food handling and meal preparation they must adhere to safe food handling practices including personal hygiene and cleanliness.

Employees should encourage their staff to undertake food handling training. The relevant competency unit is HLTFS207C Follow basic food safety practices. This is available as an online unit through the HACC Education and Training provider.

Reporting requirements

Organisations funded for domestic assistance are required to participate
in the quarterly collection of the HACC minimum data set (MDS).

For details, see Part 1: 'Reporting and data collection'.

The HACC MDS is used to record details of individual clients receiving hours
of domestic assistance.

Links

Community Services and Health Industry Skills Council
www.cshisc.com.au

National Training Package Information
http://training.gov.au

Respite

Introduction

This section describes the requirements for HACC funded respite care. Readers should also refer to:

• Part 3: 'The Victorian approach to care: the active service model'
• Part 3: 'Personal Care Policy'
• Part 2: 'Service coordination assessment and care planning'.

Respite is designed to support care relationships and strengthen the capacity of the person's carer to maintain their care role.

Respite support provides a break for the carer from their usual care role to enable them to participate in community, social and other activities. Full-time carers are considered a priority for respite support.

By providing activities to the person being cared for respite services can:

• support the person's emotional wellbeing, social inclusion and participation
• provide assistance with skills development and capacity building.

Scope

Respite services are provided to the carers of people in the HACC target population. Children in shared care or out-of-home placements may access respite care based on the carer's assessed needs.

While some service providers specialise in providing respite support for specific groups, such as carers of young people with a disability, the majority of HACC respite providers offer respite to all people in the HACC target group.

Respite is delivered either separately or as part of a flexible, responsive, integrated package of services coordinated across multiple service providers.

People may access multiple HACC respite services as well as respite services available through other programs.

Respite services:

• actively consider how to support the person and their carer in maintaining or strengthening the care relationship
• assist each person to identify their needs and interests
• provide enjoyable age-appropriate and meaningful activities
• providing accessible information to carers on support services and options available in the community.

Within this scope, respite services may be provided:

• at home, in a community venue or in the general community
• during weekdays, evenings and weekends
• on a regular basis, episodically or intermittently as needed.

Exclusions

HACC funded respite care may not be used to substitute the responsibility of another funded program.

Assessment and care planning

Respite commences with a face-to-face assessment to explore the person and their carer's needs, strengths and capabilities with a focus on supporting and strengthening the care relationship. The assessment may occur as part of a Living at home assessment or a service-specific assessment.

This assessment will include discussion about how best to:

- support the carer in their care role and care relationship
- support the person receiving the care
- maintain the person's usual routines and activities in the absence of the carer, for example by providing personal care and/or assistance with therapy or exercise programs usually provided
- ensure respite options are enjoyable and meaningful for the person.

The assessment covers the carer's need for respite as well as other supports to maintain or improve their overall health and wellbeing. This includes the provision of information from carer support groups and services such as the National Respite for Carers Program (NRCP).

In collaboration with the person and their carer, a goal directed care plan is developed based on the person's specific interests, strengths, abilities and needs.

The care plan lists:

- the person and their carer's goals
- priority areas for assistance
- agreed respite strategies to achieve goals
- how and when supports will be provided.

The allocation of respite includes considerations of the availability of a community care worker with the appropriate skills and available resources.

The care plan should document (as relevant):

- planned (regular, episodic or one-off) or emergency respite arrangements
- residential respite as available through the disability services system or aged care system, as appropriate
- the activities and supports to be undertaken during respite, including personal care (see Part 3: 'Personal Care Policy')
- emergency procedures, telephone numbers, on-call backup people and processes, including options for short term service delivery where there is a change in the care relationship, such as when a carer is ill
- staff support and accountability
- monitoring and review processes and timelines.

The allocation and continuity of community care workers should be a priority. This is determined on an individual basis, taking into account the person's and carer's needs, diversity characteristics and preferences, as well as the tasks to be performed.

Where multiple respite service providers are involved, a shared care planning process should consider the continuity of care and worker allocation.

Each person's progress is monitored and there is a clear process for the community care worker to report observed changes in the person's condition. Care plans and progress towards goals are reviewed on a regular basis.

The person and carer may increase, decrease or cease their use of respite as their needs and circumstances change.

When HACC respite services can no longer meet the needs of the person and their carer, they should be assisted to exit or transition to a more suitable service.

Community care worker role

Assessment staff, team leaders and supervisors should provide community care workers, including casual staff, with access to relevant information about the person's needs, strengths and goals from the assessment and care planning process. This will assist community care workers to:

- understand their role and the specific tasks to be undertaken as identified in the care plan
- understand their role in coaching, supervising, mentoring, or and/or motivating the person to achieve their goals
- participate as part of a broader team in optimising the person's health and wellbeing
- observe and monitor the person and their carer's progress towards their goals, satisfaction with services and provide feedback.

Respite options

Respite strategies may include in-home respite or community based respite. When responding to individual situations, respite service providers should aim to support care relationships and strengthen the capacity of the person's carer to maintain their care role.

Respite service providers should be flexible, responsive and innovative in the provision of direct care and in the planning and development of their overall service.

Respite services may be provided:

- at home, in a community venue or in the general community such as a library, recreation centre, shopping centre or park
- during weekdays, evenings and weekends so that an appropriate level of service is available at the time and frequency indicated by each person's assessed need as well as carer capacity and availability
- on a regular basis, episodically or intermittently as needed.

Service providers should inform carers that they may request to purchase additional respite, and that their request will be considered based on the organisation's capacity and the availability of staff to meet the request.

In-home respite

In-home respite refers to support provided to the person in their home. The in-home support may include:

- assistance with skill development and capacity building, such as the implementation of a specific program under the supervision of a health professional
- assistance with activities of daily living, including personal care
- support for the person to undertake activities of their choice during in-home respite
- support for the carer by undertaking light household tasks such as meal preparation, dishes or laundry, provided these do not detract from the service being provided to the person.

Where in-home respite is provided to a younger person with a disability and other siblings are present, the community care worker provides support to the family. This includes caring for all children present while focusing on the person with a disability.

In limited circumstances, where other childcare services are not available or appropriate, a community care worker may provide respite for the siblings without the child with a disability being present. An example would be if a parent has to take the child with a disability to a medical appointment, and there are no other suitable childcare options.

HACC funded respite care may not be used to substitute the responsibility of another organisation. This includes the role of school integration aides in before- and after-school programs, pre-schools, childcare services and play groups. Although a community care worker may have an established relationship with the young person with a disability, HACC funding may not be used for this purpose. However, the community care worker may be employed and funded by the other organisation to enable a flexible and responsive approach.

Community based respite

Community based respite refers to a community care worker supporting the person to participate in activities or programs of their choice in the community. Examples include accompanying and assisting the person to participate in:

- recreational activities, holiday programs or social activities
- shopping
- a cultural group or event
- a hobby or club
- social and community events.

Personal care

Where respite encompasses the provision of personal care including assistance with or monitoring of medication, the HACC Personal Care Policy must be adhered to. For the specific personal care requirements for a person with unstable/complex health needs see Part 3: 'Personal Care Policy'.

Staffing statement

For detailed information on required qualifications, refer to the staff education and training subsection of Part 1: 'Employee and related requirements'.

Organisations providing respite must have appropriate policies and procedures in place to:

- ensure community care workers adhere to the HACC Personal Care Policy (included in Part 3)
- ensure appropriate time is allocated for support and supervision of community care workers
- support the ongoing competency training and education requirements for community care workers.

Where the community care worker is involved in food handling and meal preparation, they must adhere to safe food handling including personal hygiene and cleanliness.

Employees should encourage their staff to undertake food handling training. The relevant competency unit is HLTFS207C Follow basic food safety practices. This is available as an online unit through the HACC Education and Training provider.

Reporting requirements

Organisations funded for HACC respite are required to participate in the quarterly collection of the HACC minimum data set (MDS).

For details see, Part 1: 'Reporting and data collection'.

The HACC MDS is used to record details of individual clients receiving hours of respite.

Links

Commonwealth Respite and Carelink Centres
Freecall: 1800 052 222
www.respiteseeker.com.au

Support for Carers program
http://www.health.vic.gov.au/agedcare

Carers Recognition Act (Victoria) 2012 and Victorian Charter Supporting People in Care Relationships
http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/carers-recognition-act-2012

Property maintenance

Introduction

This section describes the requirements for property maintenance and minor modification services funded by the HACC program.

Readers should also refer to the sections:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 2: 'Service coordination, assessment and care planning'.

Property maintenance services provide advice and assistance with home and garden maintenance to help people maintain a safe, habitable and healthy home environment. The services provide repairs and modifications to assist people managing disabling conditions to move safely about the house.

Services work in partnership with the person, their carer and other service providers to implement approaches which improve, restore or maintain the person's capacity to remain living independently at home.

Scope

The local context for property maintenance varies across metropolitan and rural areas, influencing the services provided.

Tasks within the scope of a HACC funded service include:

- the installation of small mobility aids, grab rails, ramps, shower rails, special taps, raised vegetable gardens or other items related to safety, independence and home-based activities
- clearing long grass or flammable materials in high fire-danger areas
- one-off garden clearing or modification to enable the person to maintain a low maintenance garden. Gardening as a physical activity has been shown to have multiple benefits, including bending, stretching, weight bearing and as a meaningful and enjoyable activity
- minor household maintenance or repairs that do not require the skills of a qualified tradesperson such as a licensed electrician or plumber. Examples include changing light bulbs where a ladder is required, replacing tap washers, minor furniture changes or installation, or painting which is necessary for safety reasons
- unblocking drains
- removal of rubbish where removal is necessary to maintain a safe home environment and there are no other practical options
- advice about other programs and services.

A HACC funded property maintenance service does not provide ongoing maintenance of lawns unless this is essential for a safe home environment, and other alternatives are not available.

Major home modifications are generally beyond the scope of a HACC funded service. At most, a HACC funded service may be able to offer assistance with one-off minor works such as conversion to a low maintenance garden or installation of shower rails.

Property maintenance in private rental or public housing should not undertake tasks which would normally be the responsibility of the landlord.

Assessment

Property maintenance services will assess the home environment and provide information and advice on works that can be undertake.

Within this scope, property maintenance services:

- work with the person to build their capacity and confidence to manage their home environment
- negotiate with the person, other family members and paid or volunteer workers to decide which activities will be undertaken and by whom
- provide assistance for essential tasks which the person has identified as a priority, but is unable, or can only partially do
- encourage people to do as much as possible for themselves, consistent with safety and maintaining a secure home environment.

Depending on the assessment, property maintenance may be provided on a routine, episodic or cyclical basis, and may increase, decrease or cease according to the person's needs.

The types of assistance provided will vary between locations, depending on the needs and abilities of the person and their carer and the priorities of service providers, as determined in response to local conditions and other locally available services.

Assessment for property maintenance and minor modifications focuses on the person's needs in relation to their home environment, in consultation with the carer.

The assessment evaluates the extent of repairs, minor modifications and cyclical or one-off tasks that may be necessary for the person's safety, security and wellbeing. Safety aspects of the assessment include:

- mobility and movement in and around the house and garden, such as ramps and rails
- tripping, slipping or falls hazards such as cracked or slippery paths, poor access points or poor lighting
- other items that may impact on safety in and around the home environment such as long grass, unsafe wiring or access routes.

Personal goals and values may be relevant in relation to property maintenance. For example, some people may be 'garden proud' or enjoy spending time in the garden and may thus place a high priority on garden maintenance, while other people may have other priorities.

Care planning

Following the assessment, and in collaboration with the person and their carer, a care plan is developed. This might occur as part of the Living at home assessment.

The plan sets out the person's goals for enhancing their home independence and safety and describes the agreed strategies for achieving them. The care plan details:

- assistance to be provided by the HACC service, family members or tradespeople
- timeframes for works to be completed
- coordination and collaboration with other service providers as required.

Where home modifications are required an occupational therapist will be involved in assessing requests. The occupational therapist will visit the home and specify requirements for the modification, such as the placement, dimensions and height of rails and other modifications, and ensure they meet appropriate standards. For more information refer to Part 3: 'Allied health'.

Offering advice and alternatives

If the assessed work requirements are beyond the scope of the HACC property maintenance service, the HACC funded agency may elect to provide the person with information about alternatives and assistance to pursue them, such as information about the statewide equipment service or home renovation service, or a list of accredited local businesses.

The agency may develop and maintain a list of local tradespeople to quote for small jobs. Assistance may be provided with obtaining quotes, negotiating with tradespeople, arranging for a service club or local community group to provide volunteers (such as for clean-ups or lawn maintenance) or fund raising.

Furniture repair may be the kind of job that can be done by a local men's shed program.

Contracting out and client co-payment

A HACC funded property maintenance service may choose either to undertake work or contract jobs to a local home repair service or tradesperson.

People are expected to pay for any materials used in property maintenance and minor home modifications. In these cases the HACC Fees Policy and the person's capacity to pay should be taken into consideration.

Alternative government programs

The Victorian Statewide Equipment Program (SWEP) provides people with a permanent or long-term disability with subsidised aids and equipment to enhance independence in their home, facilitate community participation and support families and carers in their role. Home modifications funded through SWEP include disability specific equipment to enable access such as rails, handheld showers, safety flooring, ramps and step modifications.

The Department of Human Services (DHS) manages the Victorian Home Renovation service, which works to help people of any age with disabilities to remain living independently in their own home environment. The service assesses homes to see where modifications can be made to make living at home easier and safer.

Staffing statement

HACC funded property maintenance services should be provided in a coordinated way with other HACC services.

HACC property maintenance funds can be used to hire tradespeople to undertake work at the discretion of the service provider. It is the responsibility of each service provider to determine how best to deliver the service. Services can be delivered in a number of ways including direct provision, subcontracting, or the provision of advice and referral.

HACC property maintenance is provided by people with appropriate qualifications and expertise.

HACC funded agencies must adhere to legislative or regulative requirements where the work is undertaken by licensed or registered tradespeople.

Reporting requirements

Organisations funded for property maintenance are required to participate in the quarterly collection of the HACC minimum data set (MDS).

For details see, Part 1: 'Reporting and data collection'.

The HACC MDS is used to record details of individual clients receiving hours of property maintenance.

Links

Statewide Equipment Program (SWEP)
http://swep.bhs.org.au/

Home renovation service
http://www.dhs.vic.gov.au/for-individuals/housing-and-accommodation/home-owner-support/home-modification

Home renovation loan
http://www.dhs.vic.gov.au/for-individuals/housing-and-accommodation/home-owner-support/home-modification/home-renovation-loan

Men's Sheds
http://www.mensheds.com.au/index.php?id=28

Delivered meals and centre-based meals

Introduction

This section describes the requirements for delivered and centre-based meal services funded by the HACC program.

The HACC delivered meals and centre-based meals service provides a nutritious, appetising and culturally appropriate main meal delivered to the person's home, or to a community centre where meals are eaten in a social setting.

Readers should also refer to the sections:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 3: 'Planned activity groups'
- Part 2: 'Service coordination, assessment and care planning'.

Scope

Delivered meals and centre-based meals are one option for people who are assessed as nutritionally at risk or who have decreased capacity to prepare their own meals.

Delivered meals are pre-prepared and can be delivered fresh or chilled either on a daily basis or several days in advance using frozen meals. Meals are prepared using a range of food technologies including conventional systems, cook-chill systems and cook-freeze systems.

When providing centre-based meals a suitable venue is required.

For more information refer to Part 1: 'Employee and related requirements' — information on community venues.

Please note:

- A doctor's/medical certificate is not required for consumers to receive a delivered meal or centre-based meal service
- Delivered meals and centre-based meals are not a catering service. They are for people in the HACC target population who are at nutritional risk or who have decreased capacity to prepare their own meals
- A subsidy is not provided for meals provided during a planned activity group because meal provision is included in the PAG unit price. See 'Planned activity groups' in Part 3 and 'Program funding' in Part 1.

Assessment and care planning

The assessment for delivered meals or centre-based meals may occur:

- as part of a Living at home assessment
- as a service-specific assessment.

Risk factors for poor nutritional status include:

- obvious underweight
- unintentional weight loss or weight gain
- obvious overweight affecting life quality

- recent changes that affect what the person eats, meal preparation or shopping
- reduced appetite or reduced food and fluid intake
- mouth or teeth problem
- chewing or swallowing problem (such as choking or coughing during or after meals).

The focus of the assessment is on assessing nutritional risk and providing information on supports that will enable the person to maintain or progressively improve their capacity for good nutrition. During the assessment process, the person's strengths and capabilities, diversity, risk factors, food preferences and any special dietary requirements are taken into account.

Care planning

The care plan, developed with the person and their carer, documents agreed strategies to improve or maintain nutritional status. This may include referrals for specialist intervention from a dietitian or GP.

The care plan should include capacity building strategies to re-establish and enhance the person's nutrition and independence through skills development, aids and equipment, shopping and meal preparation assistance.

Social support strategies such as a planned activity group or a friendly visiting service are important factors for people with nutritional support needs who may also be at risk of social isolation.

Delivered meals and centre-based meals may be provided separately or as part of a coordinated package of services. Delivered meal providers are required to work in conjunction with other services providers when providing meals to vulnerable or at-risk people who require monitoring. This ensures a coordinated and complementary response to meeting the person's needs.

Delivered meals may be provided on a short-term, episodic, intermittent or ongoing basis. The person's care plan details how and when delivered meals or attendance at centre-based meals will occur, and lists the date for the next scheduled review.

Information about food safety and safe food handling should also be provided to the person.

Nutritional requirements for adults

Service providers should ensure that production and delivery methods minimise loss of nutrients and physical damage to the food. In addition, food should always be presented in an appetising and attractive manner.

Meals should have a minimum of two courses, namely main course and dessert, and contain the recommended food servings.

While delivered meals provide a main meal, people should be made aware that they need two other meals during the day in order to meet their nutritional requirements.

Recommended daily intakes of nutrients

The Nutrition Committee of the National Health and Medical Research Council has established recommended dietary intakes (RDI) of nutrients for good health.

A HACC meal should provide:

• two-thirds of the RDI for Vitamin C
• one-half of the RDI for other vitamins, proteins and minerals
• at least one-third of the RDI for energy.

The recommended food servings are listed in the table below.

Vitamin C supplement

It is a condition of funding to serve a Vitamin C supplement with each meal provided.
A list of acceptable supplements is supplied in the table below.

Recommended food groups and servings

As stated above, it is recommended that each delivered meal contain two-thirds of the RDI for Vitamin C, one-half of the RDI for the other vitamins, protein and minerals and at least one-third of the RDI for energy.

This can be achieved by including the following eight food servings in each meal. Weight in grams is for cooked food, with the exception of the rice/pasta item under points two and six and the oatmeal/barley/semolina item under point six.

Each of the food group servings, plus a source of Vitamin C should be included in every delivered meal and every centre-based meal.

Table 2: HACC program delivered meals recommended servings
*Weight in grams is for cooked food, except for rice and pasta items.

Food group	Portion size*
1. One serving: meat/alternative Meat/poultry/fish Peas/beans/lentils	 75–90 grams 1 cup
2. One serving: potato/alternative Potato Rice or pasta occasionally	 90 grams 120–150 grams
3. One serving: green vegetable Green vegetable	 60 grams
4. One serving: yellow or orange vegetable Yellow or orange vegetable	 90 grams
5. One serving: fruit Fruit (cooked/prepared) Whole fresh fruit	 120 grams 1 medium

Food group	Portion size*
6. One serving: bread/cereal/alternative	
Bread	1 slice
Bread roll	1
Muffin	½
Dumpling	1
Pancake	1
Prepared breakfast cereal	1/2 cup
Oatmeal/barley/semolina	25 grams dry weight
Rice/pasta (this cannot be counted as a serve of potato)	120–150 grams
7. One serving: milk/alternative	
Milk	200 ml
Cheese	30 grams
Yoghurt	150 grams
Skim milk powder	20 grams
Cottage cheese	250 grams
8. One Vitamin C supplement: minimum amount daily	
Fresh fruit:	
Orange, small 1	50 grams
Mandarin, large 1	90 grams
Tomato, medium 1	110 grams
Grapefruit 1/2	100 grams
Pineapple, 1 whole slice -1.5cm thick	110 grams
Paw paw diced 1/3	50 grams
Cantaloupe diced 3/4 cup	100 grams
Strawberries 10 medium	70 grams
Pure fruit juice:	
Orange juice	75 ml
Grapefruit juice	100 ml
Tomato juice	200 ml
Vegetable juice	150 ml
Tropical fruit juice	150 ml
Orange and mango juice	75 ml
Apple blackcurrant juice	60 ml

Fruit juices may be supplied as:

- chilled fruit juices delivered in cartons or plastic containers, which should be stored under refrigeration for less than one month and used within 10 days of opening
- canned juices, which should be kept under refrigeration and used within two days after opening. Once opened the juice is to be dispensed into a clean food-grade container with a fitted lid.
- fresh juices, which should be squeezed daily, kept refrigerated and consumed within two days.

Menu planning

All meals provided should be based on a menu plan. Service providers who cook their own meals are directly responsible for menu development and should ensure they have the advice and ongoing input of a dietitian in the development and implementation of both their general menu and menus for individuals with special dietary needs.

Those services that purchase meals must ensure that they have a written contractual agreement with their supplier, which includes a specification based on an agreed menu.

Menu planning is based on the following principles:

- all meals meet the nutritional and portion size requirements of these guidelines
- the menu is cyclic, with a series of weekly menus designed to be used in sequence and rotated a number of times; this reduces the possibility of repetition and monotony
- the person's profile has been considered, including physical health, cultural cuisine preferences and special dietary needs
- menu items have aesthetic appeal including flavour, colour, texture and variety
- people are provided with choice and the means to express preferences and satisfaction.

Catering for individual needs

In order to cater to people's individual needs, food services require relevant information from the person or organisation providing the assessment, such as the HACC assessment service. To aid this process, the HACC assessment service should establish links with providers of delivered meals to facilitate the transfer of relevant information.

Cultural and religious requirements/preferences

Where service providers cater for people from a range of ethnic groups, they need to adopt a flexible and creative approach to providing meals. Ethnic meals may need to be incorporated into the main menu or separate menus may be needed.

Services can also tender food provision to other ethnic or religious organisations to best provide for the cultural and religious needs of their communities.

HACC assessment services should establish links with meal service providers to facilitate the transfer of information.

Special diet meals

Service providers are encouraged to meet people's special dietary requirements but are not under obligation to do so, as the primary purpose of delivered and centre-based meals is to provide a nutritious meal. Where people require a modified or special diet, this should be supplied on the basis of a letter of recommendation from a dietitian or medical practitioner.

No person should be on a modified or special diet unless the aims and benefits of this diet are clearly known to the person, their carer and the provider of the service (usually the assessment and care management service and the delivered meals provider). The person's medical practitioner or dietitian should review the need for a special diet at six and 12 month intervals and advise the service of review outcomes.

If agencies are unable to properly provide a specific type of special diet meal, they should not attempt to provide them. Nor should special diet meals be provided to all people, such as making all meals suitable for diabetics. This would potentially place people who did not need that specific special diet at risk.

Service providers should seek appropriate information from a dietitian or medical practitioner regarding the details of any diet requested to ensure the service provider can meet the requirements of the diet. If a particular diet or dietary requirement cannot be provided properly by the service, the consumer should be assisted to find an alternative provider.

Monitoring the person's wellbeing and other circumstances

Historically, funded organisations have often used home-delivered meals as a way of supporting and monitoring the wellbeing of people receiving services and/or providing some daily social contact for isolated individuals. Sometimes delivered meals are used in this way because they are the only service a person will accept or there is not another appropriate service available.

While it is still a requirement of meal deliverers to monitor the wellbeing (and other circumstances) of the person receiving the meal, and to report any concerns back to their supervisors, in general this should not be the primary reason for a person to receive a delivered meal. Funded organisations should ensure that consumers who require monitoring or social contact receive a more appropriate service where possible.

Delivered meal providers are required to work in conjunction with other services, whether or not they are HACC funded, when providing meals to vulnerable or at-risk people who require monitoring. This ensures a coordinated and complementary response to meeting the person's needs. Meal deliverers should be instructed to report back any comments or concerns about service users. Meal deliverers should have an opportunity to give this important feedback to their supervisor after each delivery.

Service access

Access to delivered meal services can be improved using a range of strategies. These strategies address problems that may prevent the person receiving meals from meeting their nutritional needs.

Geographic access

Service providers must ensure that all geographic areas in their catchment can be supplied with home-delivered meals when required. In isolated areas this may mean delivering frozen meals two or three times a week, or using other HACC services such as home care workers or nursing services to deliver meals. In some isolated areas innovative responses have been used such as contracting local pubs or restaurants to provide or deliver meals.

Using frozen meals to enhance access

While all delivered meals services should provide meals for 365 days of the year, frozen meals can be left on a Friday or a weekday for weekend or public holiday consumption. This is not the case for hot meals or chilled meals, which must be delivered daily, and must not be left on Friday, or a weekday, for weekend or public holiday consumption. Frozen meals can be used for this purpose because freezing is the only way to maintain a safe and continuous food temperature in the home environment.

Service providers are advised not to leave hot meals when no one is home due to the risk of deterioration or contamination. However, special arrangements should be made if the person is unable to receive the meal and other arrangements, such as a neighbour or friend picking up the food, are not possible. Some of these alternatives include:

- arranging to deliver a frozen meal in advance
- delivering the hot meal at a time when the person is home
- assessing whether the person would be more appropriately supported through assistance with shopping and meal preparation rather than delivered meals.

Purchasing or contracting

Where a HACC funded organisation purchases meals from another source or subcontracts meal production, there must be a written contract and a written meal supply specification with the supplier that includes all the requirements of the *Victorian HACC program manual*. This contract should include procedures regarding communication, comment from the people receiving the meals and menu planning.

Food safety requirements for HACC meals

Delivered meal service providers must be familiar with legal requirements in the area of food safety and must ensure that paid and unpaid staff receive appropriate information and training. It is the responsibility of providers to ensure that the practices of their delivered meals service comply with all regulatory requirements.

Victorian food laws

Victorian food safety laws affect every Victorian's health and safety. Food-borne pathogens can cause severe illness and even death in vulnerable people.

Under the *Food Act 1984*, all food business owners and community groups who sell food are legally responsible to ensure that food sold or prepared for sale is safe to eat.

The Act also requires food premises to comply with the Food Standards Code. The code is a collection of individual food standards developed jointly by Australia and New Zealand. It is a criminal offence in Australia to supply food that does not comply with relevant food standards.

It is also an offence to sell food that is damaged, has deteriorated or perished, is adulterated or is unfit for human consumption.

This means that all staff who handle and prepare food for sale are responsible for food safety, not only the business owner/proprietor.

From 1 July 2010, changes to the *Food Act 1984* came into effect. These changes are intended to improve Victoria's system for regulating the safety of food sold for human consumption.

If you run a food business, you need to understand the impact of these changes on your organisation. Your local council environmental health officer will assist you to understand and comply with your obligations.

See also free guidance materials on the Victorian Department of Health food safety website.

Food premises classification and registration

The *Food Act 1984* adopts a preventative approach to food safety. It groups food premises into separate classes, and sets out different food safety requirements for each class based on the food safety risks of its highest risk food handling activity. There are four classes — from highest risk (class 1), such as a nursing home, to lowest risk (class 4), such as a newsagent selling only pre-packaged confectionery.

The level of regulation is largely determined by the microbial hazards posed by food handling onsite. The greater the chance of something going wrong during the food handling process, and the greater the potential impact on people's health, the higher the level of regulation.

Local councils are responsible for classifying every food premises within their municipal districts under the Act. The Department of Health has developed a food business classification tool that outlines a wide range of food business activities and applies a classification of 1 to 4 according to the food safety risk of each activity. HACC funded delivered meals organisations that prepare ready-to-eat meals for delivery to vulnerable persons fall under class 1, the highest risk category.

Home-delivered meals

To ensure high standards of food nutrition and safety the following information is provided regarding food delivery processes:

- the suitability of vehicles used in the delivery of meals should be considered in accordance with national food safety standards
- individual meal containers should be disposable aluminium foil or microwave-safe plastic and have the meal production date shown (handwritten or labelled)
- funded agencies should ensure that non-disposable food carriers/containers and insulated carriers are cleaned before they are reused
- insulated containers should be used to transport individual meals at all times, whether as a large number in a car or a small number delivered by hand
- frozen meals should be placed in a person's freezer and chilled meals placed in the refrigerator. Care should be taken that meals are stored in order of production
- food deliverers should ensure that consumers are capable of independently preparing frozen or chilled meals. Any problems or concerns should be immediately reported to a supervisor
- meals should not be left if there is no one at home unless there is a specific, predetermined arrangement.

People receiving meals

Information on food safety and safe food handling should be provided in a form that people can understand and use. Meal deliverers should inform people about the correct handling of the meal, reminding them to eat their hot meal when they receive it.

Staffing statement

All food premises that operate in Victoria need to ensure their food handlers have the skills and knowledge required to keep food safe in the workplace.

This requirement means anyone in a business or community group that prepares food has surfaces likely to come into contact with food must know how to keep food safe from contamination.

For important information about the skills and knowledge required by food handlers, please refer to the department's food handler skills and knowledge information sheet, provided in the links section at the end of this chapter.

Volunteers

Volunteers should be given information on the delivered meals service and kept up-to-date with any relevant information about menu or delivery changes so they can inform service users.

For more information on recruiting, training and the support of volunteers, refer to Part 3: 'Volunteer coordination'.

Meal deliverer's role

It is the meal deliverer's role to:

- deliver meals safely
- monitor the person's wellbeing and other circumstances
- provide the person with information.

Funded organisations should ensure that meal deliverers (whether paid or voluntary) are kept fully informed about the menu and service so that information can be conveyed to and from people receiving meals. To assist people receiving meals, meal deliverers can:

- distribute a newsletter
- distribute a consumer satisfaction survey
- provide information about the meal delivery service
- monitor food handling and storage.

Reporting requirements

Organisations funded for food services are required to participate in the quarterly collection of the HACC minimum data set (MDS).

For details see, Part 1: 'Reporting and data collection'.

The HACC MDS is used to record details of individual clients receiving delivered meals, and the number of meals received during the quarter.

Links

Victorian Department of Health food safety website www.health.vic.gov.au/foodsafety

Food business classification tool http://www.health.vic.gov.au/foodsafety/foodclass/index.htm

Food handler skills and knowledge information sheet
http://www.health.vic.gov.au/foodsafety/skills_knowledge/food_handler.htm

Food Act 1984 http://www.legislation.vic.gov.au/domino/Web_notes/LDMS/LTObject_Store/
LTObjSt2.nsf/d1a8d8a9bed958efca25761600042ef5/d104b68ff611fe30ca257761001fc67a/$FI
LE/84-10082a080.pdf

Community Services and Health Industry Skill Council http://www.cshisc.com.au/

National training information http://training.gov.au/

Planned activity groups

Introduction

This section describes the requirements for HACC funded planned activity groups. Readers should also refer to:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 3: 'Personal Care Policy'
- Part 2: 'Service coordination, assessment and care planning'.

Planned activity groups support people's ability to remain living in the community by providing a range of enjoyable and meaningful activities. These activities support social inclusion, community participation, and build capacity in skills of daily living.

Scope

Planned activity groups are designed to enhance people's independence by promoting physical activity, cognitive stimulation, good nutrition, emotional wellbeing and social inclusion. For people with carers, planned activity groups are also designed to support care relationships.

Planned activity groups may be targeted broadly to the HACC target group or to particular subgroups such as people with dementia, carers only, or carers together with the person they care for.

A person receiving a Home Care Package is eligible to attend a HACC-subsidised planned activity group. For further information see Part 2: 'Interface programs'.

Assessment and care planning

The assessment for planned activity groups may occur as part of a Living at home assessment or as a service-specific assessment conducted by the planned activity group coordinator.

The assessment explores the needs of person and their carer for social and other support.

The assessment process includes:

- discussion about the person's strengths, capabilities, interests and underlying need for support
- a focus on any nutritional issues, physical activity, emotional wellbeing and social skills
- consideration of the carer and the care relationship including identification of broader carer needs
- personal care assessment in accordance with the 'Personal Care Policy' refer to Part 3.

Each person attending a planned activity group will have an individualised care plan. The care plan lists the person's goals, what they are interested in achieving by attending the planned activity group and agreed strategies to achieve these goals.

The care plan may also include:

- referral to a local HACC assessment service for a Living at home assessment if the person or their carer identifies needs beyond the scope of the service
- referrals to other services
- information on local social or recreational activities in the area and how to access them.

People may increase, decrease or cease their use of planned activity groups for a range of reasons. Examples include when:

- the person has achieved their goals
- the person has made links with other community groups or been connected with other social opportunities
- there has been a change in the needs of the person and carer.

In these situations the person should be assisted to transition or exit from the planned activity group. Information should be provided about how to access the service if required in the future.

Activity options

A wide range of activities may be provided as part of a planned activity group. All activities should be designed to respond to the person's, and if applicable their carer's, assessed needs, goals and interests.

Activities are delivered in a range of accessible, safe venues and settings suitable to participants. Older and frail people have different environmental requirements from younger people with a disability.

Activities can be provided:

- in community venues or general community facilities such as libraries, recreation centres, shopping centres and so forth
- during weekdays, evenings and weekends
- on a regular basis, short term, episodically or intermittently as needed.

Activities should:

- be part of a planned program designed to enhance social interaction and build capacity in activities of daily living
- balance the needs and preferences of each participant with the overall needs and preferences of the group
- be flexible, short-term and interest based in order to meet a range of needs and interests
- be designed so that individualised activities can occur within a group setting.

The size and structure of planned activity groups should support and maximise social interaction between participants. Smaller groups are more likely to assist people to develop and maintain social skills. Activity groups should also support people with different interests by offering a range of activities within each group.

Below are examples of typical activities:

- indoor activities such as cards, games, music, food preparation and shared lunches
- outdoor activities including group outings and picnics
- targeted gentle exercise programs such as tai chi and chair-based yoga
- education and information on nutrition awareness, condition awareness (diabetes, dementia) and healthy eating.

Please note that the implementation of targeted gentle exercise programs such as tai chi require participants to be assessed for suitability by an appropriately qualified person prior to their participation.

Working in partnership

Service providers need to develop links and partnerships with local communities and service providers. This includes:

- partnering with allied health services to provide specialist expertise in designing and delivering activities such as gentle exercise, healthy eating and other health promotion programs and messages
- developing partnerships with a broad range of community groups to support the person's transition to ongoing activities or groups in the local community, for example attending the local leisure centre or gym
- developing links within the local community to communicate the service to potential clients and carers.

Planning and development

In planning and developing planned activity groups, service providers should ensure that:

- participants are involved in planning activities and programs and in evaluating the extent to which the programs meet their interests and preferences
- activities reflect the diversity, interests and preferences of participants and create opportunities for fun, enjoyment and social interaction, both with other group members and the broader community
- activities balance the needs and preferences of each person with those of the group
- activities connect people and engender social interaction
- activities promote and support healthy eating, physical activity and emotional wellbeing
- there is a balance between social, intellectual and physical stimulation
- activities are designed to foster daily living skills and promote independence
- activities occur in a variety of settings and are not limited to a single venue
- activities are available during daytime, evening and weekends based on the person's needs and interests and the available resources.

Well for Life

Well for Life has been operating in Victoria since 2003. Well for Life initiatives use health-promoting principles to focus on improving physical activity, nutrition and emotional wellbeing for older people.

A range of Well for Life fact sheets and resources can be used to assist the running of planned activity groups.

Other requirements

Food services

Participants should be provided with a main meal if they are attending a planned activity group at the time when a main meal would usually be eaten.

If your Planned activity group is preparing meals you should check the Department of Health Food Safety laws website to ensure you are compliant with the Victorian Food laws.

Where the community care worker is involved in food handling and meal preparation they must adhere to safe food handling practices including personal hygiene and cleanliness.

Employees should encourage their staff to undertake food handling training. The relevant competency unit is HLTFS207C Follow basic food safety practices. This is available as an online unit through the HACC Education and Training provider.

Personal care

Where a person attending a planned activity group requires personal care, including assistance or monitoring of medication, the HACC Personal Care Policy must be applied. For more information refer to Part 3: 'Personal Care Policy'.

Transport

Transport options to and from planned activity groups should be discussed with the person and their carer as part of the care planning process. Transport assistance may be provided by paid staff or volunteers.

If people use their Multi Purpose Taxi Program (MPTP) card to travel to or from planned activity groups, it must be used in line with the MPTP terms and conditions.

For further information see Part 1: 'Employee and related requirements'.

Use of volunteers

Volunteers are involved in many planned activity groups. It is the role of the coordinator to recruit, train and support volunteers where volunteers are used.

HACC funding for volunteer coordination is not available to support volunteers assisting PAG activities. This means that while a volunteer coordinator can assist a PAG coordinator with the recruitment of volunteers, they do not have an ongoing role in the support and management of PAG volunteers.

The support and management of PAG volunteers is part of the PAG coordinator's role.

For further information see Part 3: 'Volunteer coordination'.

Catchment planning

Service providers within a geographical catchment should coordinate services to best respond to a wide range of participant needs and interests, within available resources.

Costs

The delivered meals subsidy is not available for meals provided during a planned activity group as food costs for activities that are planned around a mealtime are included in the PAG unit price.

Where the organisation purchases a HACC delivered meal into the PAG, the person can be required to pay the HACC delivered meal client contribution in addition to the PAG fee.

Planned activity group participants can be asked to pay for transport, material costs, excursions and the cost of a meal if it is purchased from another source. These items can be charged in addition to the planned activity group fee as appropriate.

Fees must be charged in accordance with the HACC Fees Policy. Where fees are charged, revenue is to be used to enhance service provision or provide additional hours of service.

Roles and responsibilities

Role of coordinator

The coordinator's role and responsibilities include the following activities. These activities should be undertaken by the coordinator or by other appropriately qualified staff. Activities include:

- developing processes for engaging participants and carers in the ongoing development, planning, review and evaluation of activities and programs
- taking account of diversity and the needs and preferences of participants when planning programs and activities
- individual assessment, care planning, monitoring, review and referral to other services as required
- using the individual care planning process and people's goals to inform the planning and design of programs and individualised activities
- providing clear processes for community care workers and volunteers to monitor, observe and provide feedback on the programs and activities
- developing partnerships with other service providers, such as allied health services and community groups to enable community access and bring relevant expertise into the organisation as required
- administering duties including budget planning, management and monitoring
- staff and volunteer recruitment and training, including ongoing supervision and support
- service planning, promotion and development
- program review, evaluation and continual quality improvement
- seeking feedback on programs and activities from a range of people including participants, carers and volunteers.

In some cases the coordinator may assist in the provision of personal care in accordance with the HACC Personal Care Policy.

Role of community care workers

Community care workers play a significant role in delivering planned activity groups, implementing activities and facilitating social interaction.

They are part of a broader team working with the person to optimise their health and independence, and play a key role in monitoring the person's progress towards their goals.

Coordinators should ensure community care workers, including casual staff, have access to relevant information from the assessment and care planning process. This information should enable an adequate understanding of the person's needs, strengths and goals.

Community care workers need to be trained and supported in order to:

- meet participant's individual needs and provide a high standard of quality care, including personal care
- have the relevant skills and knowledge to undertake a variety of activities
- assist with gentle exercise programs following non-transferable skills training (see Part 3: 'Personal Care Policy')
- facilitate small-group interaction
- monitor, observe and provide feedback on participant satisfaction with the programs and activities
- avoid becoming involved with participants in a manner which is outside the boundaries of their role.

Staff ratio

Planned activity groups are funded as either 'core' or 'high' groups. Each group has a different paid staff ratio.

Core groups tend to have participants who are physically independent and do not require personal care assistance or specialist care to participate in the group. The recommended ratio is one paid staff member to seven participants.

High groups tend to have participants who require additional assistance to participate. For example, the participant may have dementia or require personal care or other specialist care to participate. The recommended ratio is one paid staff member to five participants.

Café style support

Café style support is a model of service delivery that offers social support to a person and their carer at the same time, in the same place, in a community based setting such as a café or similar community venue.

The broad goals of café style support are to:

- provide support to people in care relationships through a social opportunity
- assist participants to develop social connections with people in similar circumstances
- provide health and service information on issues of interest to participants, through links and partnerships with other service providers
- develop participants' confidence to independently engage with the formal service system.

See *Café Style Support: Practice guidelines for HACC services in Victoria* (Department of Health 2013).

Staffing statement

For information on required qualifications, refer to Part 1: 'Employee and related requirements'.

Appropriately qualified staff should be used to conduct specific planned activities, such as allied health activities or exercise programs.

Where community care workers are involved in food handling and meal preparation they must adhere to safe food handling practices including personal hygiene and cleanliness.

Organisations providing planned activity groups must have appropriate policies and procedures in place to:

- ensure appropriate time is allocated for support and supervision of community care workers and volunteers
- support ongoing competency training and education requirements for community care workers and volunteers.

Reporting requirements

Organisations funded for planned activity groups are required to participate in the quarterly collection of the HACC minimum data set (MDS).

For details, see Part 1: 'Reporting and data collection'.

The HACC MDS is used to record details of individual clients attending a PAG. In general, countable time comprises the time each individual spent with the group.

For information on funding for Café Style Support Services see: *Café Style Support: Practice guidelines for HACC services in Victoria* (Department of Health 2013).

Links

Well for Life
http://www.health.vic.gov.au/agedcare/maintaining/wellforlife.htm

Victorian Department of Health food safety website
www.health.vic.gov.au/foodsafety

Café Style Support: Practice guidelines for HACC services in Victoria (Department of Health 2013)
www.health.vic.gov.au/hacc/publications

Linkages

Introduction

This section describes the requirements for the HACC funded Linkages activity. Readers should also refer to:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 2: 'Service coordination, assessment and care planning'.

The objective of the HACC Linkages activity is to support people with complex care needs. This support is designed to assist people to live independently in the community by providing individually tailored packages of care and case management to delay admission to residential care.

Scope

Linkages are designed for people with complex care needs that cannot be fully met by the usual level of HACC services, or who would gain particular benefit from case management.

Linkages case management assists a person and their carer to access a range of supports based on their goals, aspirations and needs, to improve and/or maintain their capacity to remain living independently in the community.

A Linkages package is essentially flexible funding to purchase additional hours and/or a greater range of services than would otherwise be available. Funding is typically used to employ staff, purchase or subcontract services and buy equipment.

The Linkages case management process involves:

- screening for eligibility
- holistic assessment in partnership with the person and their carer of the person's strengths, capabilities, aspirations and goals
- consideration of current service use and determination of additional services needed
- consultation with the person and their carer to develop a holistic, goal directed care plan, including activities to promote various aspects of health and wellbeing and to enhance their ability to live and participate in the community
- care plan implementation and care coordination
- regular monitoring and review of the person's progress and situation, with adjustments to goals and service delivery as appropriate
- managing the person's exit or transition from the service.

Within this scope, Linkages providers:

- work in partnership with other health and community service organisations to ensure an integrated approach
- provide services within the package that may be short-term, episodic or longer-term as the needs of the person or their carer change
- purchase additional services that are a priority for the person and their carer and that will enhance their independence.

Exclusions

A person receiving a Commonwealth Home Care package is not eligible for a Linkages package.

A person receiving an Individual Support Package (ISP) is not eligible to receive a Linkages package.

For further information on these programs refer to Part 2: 'Interface programs'.

Assessment and care planning

Following a self-referral or referral by another service provider, Linkages commences with a face-to-face assessment with the person and their carer in their home environment.

This assessment covers relevant health, functional, social and environmental issues. As this is a comprehensive assessment, it is not necessary to refer the person for a separate Living at home assessment.

Linkages are targeted to people with complex needs who require case management and support services in order to remain living independently in the community. Indicators of complex needs include when the person:

- has a range of interacting physical, medical, social and emotional needs
- requires assistance to organise and coordinate their care
- requires assistance to coordinate their formal and informal supports
- has difficulty in accessing HACC services which are sufficiently flexible to meet their needs
- has additional needs as a result of their diversity (for more information see Part 2: 'Diversity')
- has needs that may rapidly change and require frequent monitoring
- has a carer whose quality of life is significantly compromised by their care role and requests assistance.

Not everyone who has complex needs will require a Linkages package. The differentiating point is the requirement for case management, and the need for additional support services to live independently in the community.

Following a Linkages assessment, the case manager and the person and their carer develop a goal directed care plan. This plan should include strategies to achieve the person's goals and detail services to be provided by HACC and other programs or providers.

Supports are planned and delivered in a manner that reflects the person's and carer's priorities and preferences. The focus of supports is on restorative care and maintaining and/or enhancing the person's capacity to live independently in the community.

The effectiveness of the care plan is monitored through the case manager's communication with the person, carer and other participating service providers. The care plan should include a timeframe for review, updating and progress towards outcomes.

Transition from Linkages

Transition planning is an essential part of overall care planning. Any planning for a transition from a Linkages package should involve the person, their carer and other service providers. Alternatives to Linkages should be sought in the following situations:

- the person's situation improves and Linkages is no longer required
- the person's needs cannot be adequately met in the community with available resources, and transition to an alternative program is appropriate. Possible alternatives include:
  - a Commonwealth Home Support Package
  - an Individual Support Package (see Part 2: 'Interface programs')
- the person's living arrangement has changed or they have requested alternative care
- the person's needs have exceeded the reasonable capacity of a Linkages package, and the service is an inappropriate substitute for residential care.

Maintenance of effort

The role of Linkages is to purchase additional services that supplement hours of HACC service delivery.

People going on to a Linkages package should continue to receive HACC services they were receiving, as appropriate to their needs and circumstances.

This is referred to as 'maintenance of effort'. The principles of maintenance of effort are that

- People should continue to receive HACC services at the same level as the average amount received by other clients of the particular HACC organisation.
- From a person-centred perspective the Linkages service and the HACC organisation should work together to determine what maintenance of effort arrangement will deliver the best outcome for the person in their particular circumstances.

Linkages funds

Linkages funds should be used to provide services and equipment which will make a critical difference to assisting the person to remain living in the community. Package funds should be used to:

- provide services, items or equipment that are consistent with HACC aims and objectives
- purchase high-quality services, items or equipment with due regard to cost effectiveness.

Package funds should **not** be used to pay for items that constitute normal living expenditure, such as utility bills, rates or food - although delivered meals or food preparation assistance are acceptable. The intent of the flexible care funds should be considered.

Package funds should not be used to purchase equipment where this is the role of another funded agency or program such as the Statewide Equipment Program (SWEP). If no other agency or program is responsible for purchasing or providing the equipment, Linkages flexible care funds can be used.

Equipment purchased by Linkages remains the property of the Linkages service and is returned by the person, if practical, when they cease using the service. The cost of servicing the equipment is negotiated and may rest with the equipment user, owner or be a shared arrangement. Hiring of equipment, which may include servicing in the hire fee, may be a more suitable option than equipment purchase.

HACC services may be purchased at, or lower than the HACC unit price as negotiated with the service provider.

Staffing statement

Linkages case managers are expected to provide case management for an average of 25 to 30 people at any time. However, this case-load may vary considerably due to case complexity and a range of other factors. The skills and knowledge required by case managers include:

- a detailed knowledge of both the ageing process and the needs of younger people with a disability
- a detailed knowledge of the needs of specific groups such as the HACC special needs groups and people with diverse needs
- a professional qualification in a health and community services discipline
- previous direct experience in working with people with complex needs in the HACC target group
- knowledge or experience of the active service model and a person-centred approach.

Subcontracting

Linkages may subcontract another agency to provide a specific service. The arrangement must be documented in a written contract which specifies, as a minimum:

- quality compliance
- the type of service purchased and agreed service levels
- expectations of the service provider, such as quality services, staff qualifications and pre-employment checks
- cost, accounting and invoicing procedures
- risk management requirements, for example OHS and insurance policies
- data collection and reporting requirements
- procedures for breach of contract and dispute resolution
- contract period and review date.

In considering subcontracting arrangements the Linkages agency is required to consider continuity of care and best value.

Regardless of the method of service delivery, overall responsibility for the person's outcomes, particularly quality assurance and consumer rights, remains with the Linkages provider.

Reporting requirements

Organisations funded for Linkages are required to participate in the quarterly collection of the HACC minimum data set (MDS). Subcontractors should report data to the organisation that has a direct funding link to the department. This organisation will in turn report to the department via the HACC MDS.

For details, see Part 1: 'Reporting and data collection'.

The HACC MDS is used to record details of individual people receiving a package. Note that there is no MDS activity type called 'Linkages'. Instead, use the relevant MDS activity types (such as personal care), recording the hours that were paid out of the Linkages package. Ensure that all Linkages funds expended on services for a particular person are accounted for in terms of hours, in the MDS report.

Links

HACC diversity planning and practice
http://www.health.vic.gov.au/hacc/projects/diversity_framework.htm

HACC Assessment framework
http://www.health.vic.gov.au/hacc/assessment.htm

Statewide Equipment Program (SWEP)
http://swep.bhs.org.au/

Service system resourcing

Introduction

Service system resourcing is focused primarily on activities and roles that:

- operate at a systemic level with system-wide impacts and benefits for the HACC service system
- are not generally targeted to service users.

A diverse range of activities may be funded, including:

- capacity building roles which work at a systemic level, such as community service officer roles, ASM industry consultants, HACC diversity advisers and development officers
- activities involved in implementing the *Vulnerable People in Emergencies Policy*, in particular identifying, planning with and screening vulnerable people not receiving services. See Part 1: 'Victorian policy and program directions'
- equal remuneration (the SACS award top-up)
- contributions to the maintenance of senior citizens centres.

Systemic and capacity building roles

Service system resourcing is used to fund a range of roles designed to improve the accessibility and responsiveness of HACC services. These roles work at a systemic level and include:

- community service officers (CSOs)
- development officers
- ASM industry consultant (ICs)
- HACC diversity advisers (HDAs).

Community service officer roles

Community service officers (CSO) perform service planning, development and coordination functions.

Examples of these functions include:

- coordinating, monitoring and evaluating services
- developing local policy and monitoring the implementation of HACC policy and standards
- developing and resourcing a collaborative approach to local planning and quality initiatives such as the active service model
- collating and analysing information about HACC target populations, service usage, the needs of particular target groups and how the active service model can be applied
- identifying unmet need and developing strategies and services to meet that need
- developing effective communication between service providers, government agencies, community organisations and people using services.

Development officer roles

While the development officer role can support different target groups, a major component of the role is funded work within Aboriginal community controlled organisations (ACCOs).

This program aims to enhance the capacity of HACC funded organisations to provide HACC services to Aboriginal communities. In particular the role focuses at a systemic, regional level, on supporting the capacity of ACCOs to provide HACC services to their respective Aboriginal communities.

Development officers work in partnership with ACCOs to ensure ACCOs:

- have a good understanding of the HACC program
- are able to identify and prioritise HACC service issues
- continually improve service system outcomes for their respective Aboriginal communities.

As part of this role, development officers:

- coordinate HACC Aboriginal regional network meetings
- facilitate communication between the network and the statewide HACC Victorian Committee for Aboriginal Aged Care and Disability (VCAACD)
- identify HACC Aboriginal staff training and professional development needs and source training and professional development opportunities in collaboration with VCAACD
- provide support and orientation for HACC Aboriginal staff
- assist ACCO boards of management and HACC Aboriginal staff to gain access to information about the HACC program and HACC administrative requirements
- assist in enhancing Aboriginal communities' understanding of the HACC program
- collaborate with ACCOs, mainstream services and the department to assist in the development of culturally appropriate processes and protocols to improve Aboriginal access to a range of services.

ASM Industry consultants (IC)

Industry consultants have been employed by the department both in central office and within each region to support organisations to implement the ASM approach in a coordinated and consistent way.

The aim of the regional ASM industry consultant positions is to support the implementation of the active service model through

- Being the key communication point for ASM developments and information within the region.
- Assisting HACC funded organisations within the region to gain a consistent understanding of the ASM approach and its implications for practice and systems.
- Providing practical operational support to organisations to put the ASM approach into practice as a broad sustainable change management strategy.
- Assisting in the broader implementation of the ASM initiative through sharing information on barriers, enablers and practice learnings and developments at a regional and statewide level.

For further information refer to Part 3: 'The Victorian approach to care: the active service model'.

HACC diversity adviser (HDA) roles

Diversity planning and practice aims to improve access to services for eligible people who are marginalised or disadvantaged due to their diversity, and to improve the capacity of the service system to respond appropriately to their needs.

Under the banner of diversity planning and practice, the HDA role is designed to focus at a systemic, regional level, to support the implementation of diversity planning and practice by HACC funded organisations.

The HDA has a key role in facilitating change, communicating key diversity planning and practice concepts, and providing implementation support.

HDA responsibilities include:

- promoting and facilitating diversity planning and practice within a region and across the funded sector
- promoting the development of HACC funded organisations' diversity plans, for example through the provision of data and facilitation of processes
- facilitating networks, forums and partnerships (where these do not exist) to ensure collaborative approaches to enable diversity and access issues to be identified and addressed at the regional and local level.

HDAs work collaboratively with the department's central HACC unit office, the regional ASM industry consultant and regional HACC PASA to support HACC funded agency diversity planning and practice.

For further information refer to Part 2: 'Diversity'.

Response service for Personal Alert Victoria (PAV)

The objective of the response service for Personal Alert Victoria is to be the incident contact for people using Personal Alert Victoria (PAV) and for people without family or other informal contacts (as defined in the *Response service guidelines*).

Response to an incident or potential incident can be triggered by a person pressing their incident alarm button, or because the person has not made their daily call to PAV and cannot be contacted by PAV. In these circumstances, the response service will provide a prompt home visit. This service is available 24 hours a day, 365 days a year.

The *Response service guidelines* (January 2013) document the eligibility, assessment and registration requirements for the response service along with the procedures and processes required to implement the service.

These guidelines constitute part of the *Victorian HACC program manual* (2013) and should be read in conjunction with the *Personal Alert Victoria program and service guidelines*.

Delivered meals organisations

A small allocation is provided to delivered meals providers to support up to two dietetics forums per annum. These forums are run by a dietitian in order to improve managers and staff understanding of nutritional needs, risk and the type of support that dietitians can provide to clients.

Senior citizens centres

The HACC program is delivered in a range of facilities and venues across Victoria. Local governments make a significant contribution to the ongoing operational costs of some venues.

HACC funding may be available to contribute to the maintenance of senior citizens centre buildings.

Staffing statement

Staff delivering programs or activities funded through service system resourcing must hold the relevant qualifications as outlined in Part 1: 'Employee and related requirements'.

Reporting requirements

HACC diversity advisers and other employees in systemic roles file their reports according to the agreed reporting measures and framework of the service activity report.

Reporting for grants and other initiatives is specified in the funding agreement.

Links

Active service model
http://www.health.vic.gov.au/hacc/projects/index.htm

Diversity
http://www.health.vic.gov.au/hacc/projects/diversity_framework.htm

Vulnerable People in Emergencies Policy 2012
http://www.dhs.vic.gov.au/funded-agency-channel/spotlight/vulnerable-people-in-emergencies-policy

Personal Alert Victoria guidelines
http://www.health.vic.gov.au/agedcare/downloads/pav/pav_guide_2010.pdf

Response service for Personal Alert Victoria
http://www.health.vic.gov.au/hacc/prog_manual/downloads/response_guidelines.pdf

Volunteer coordination

Introduction

This section describes the requirements for HACC funded volunteer coordination.

Readers should also refer to:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 2: 'Service coordination, assessment and care planning'
- Part 1: 'Employee and related requirements'.

Scope

Volunteer coordination recruits, trains and supervises volunteers to provide a broad range of services and support including: friendly visiting; telelink; carer support; stand-alone transport services; and host carer programs.

In most instances in volunteer coordination it is the volunteer, not the paid volunteer coordinator, who has a direct support role with the person receiving HACC services.

Exclusions

HACC funding for volunteer coordination should not be used to support volunteers within planned activity groups. This is the role of the planned activity group coordinator. However, volunteer coordination funding can be used to identify and recruit potential volunteers for planned activity groups.

Volunteer coordination-other

See Part 1: 'Program funding' for information on funding for Volunteer Coordination including block funding (Volunteer coordination-other) to cover volunteer program costs including volunteer re-imbursement.

Volunteer coordinator role

The role of a volunteer coordinator typically includes:

- marketing and promotion
- recruitment of volunteers for their own and other HACC services — recruitment should reflect the diversity of people seeking volunteer support
- training volunteers in relation to the scope of their role and the active service model
- ensuring that volunteers work within their scope and **do not:**
  - perform nursing duties including medication administration or changing dressings
  - undertake personal care
  - accept money or gifts
  - become involved or responsible for a person's property, assets or financial affairs
  - give legal, financial, medical, professional, cultural or religious advice
- conducting a service-specific assessment of the person's and carer's needs for volunteer support
- liaising with other service providers to ensure that volunteer support for a person occurs as part of an overall response and care plan

- matching volunteers with individuals, taking account of diversity
- overseeing administration and compliance requirements for volunteers such as volunteer Police Record Checks and volunteer Working With Children Checks
- volunteer rostering, monitoring, supervision and recognition
- administration such as data collection, reporting and reimbursing volunteer's approved expenses
- implementing policy and procedures, and continual quality improvement processes.

Use of volunteers

HACC funds the volunteer coordination activity so that staff are available to recruit, train, support and supervise volunteers to provide:

- friendly visiting, where a volunteer regularly visits the same person to provide companionship
- telelink services, where a group telephone call is scheduled at a regular time
- carer support programs (if necessary volunteer coordinators can also run carer support services themselves, without volunteers)
- stand-alone transport services that use volunteer drivers
- respite, including host carer programs such as those provided by volunteer respite services for families of children with disabilities
- delivering meals for a HACC delivered meals service where the delivered meals organisation does not receive volunteer coordination funding
- respite camps and weekends, where volunteers assist in running the camp
- short-term group activities, such as small local walking groups for people with shared goals. Note that each person's physical capacity must first be assessed by an appropriate health practitioner before taking part in a volunteer-led or facilitated physical activity group
- support to help people develop their own social networks, for example, by linking a person to a community of interest or local neighbourhood group.

Volunteers may also undertake administrative activities such as the preparation of newsletters, office assistance and organising transport.

All volunteers, regardless of whether or not they are in a direct contact role, must:

- be aged 18 years and over
- have completed the necessary Police Record and Working With Children Checks
- provide a minimum of two referees.

While there is no upper age limit for volunteers, organisations should check their insurance policies. For further information refer to Part 1: 'Employee and related requirements'.

Processes

Organisations funded for HACC volunteer coordination must have a documented process that outlines the recruitment, selection, training, support and monitoring of volunteers. Volunteers must be adequately supervised and supported by the volunteer coordinator, including via regular meetings and communication regarding the person.

Volunteer coordination aims to recruit and have available an adequate number of volunteers.

Potential volunteers should be provided with written information, undergo a formal interview, complete Police Record and Working With Children Checks, and undergo comprehensive reference checks. On the basis of this evidence volunteer coordinators will make a decision about the person's suitability for the role.

As the role of volunteers varies between services and with each person, every volunteer should be provided with a written duty statement outlining their role, responsibilities, information privacy and activities which are outside the scope of their volunteering role. Volunteers must provide evidence of their legal capability to undertake their role such as up-to-date driver licence and insured private vehicles.

All volunteer coordination organisations should have a written volunteer reimbursement policy.

The input and role of a volunteer should be clearly documented in the person's care plan to ensure that the support is provided in the context of their goals and is adequately monitored and reviewed.

People may increase, decrease or cease their use of volunteer support for a range of reasons. Examples include when:

- the person has achieved their goals
- the person has connected with a community group or other social opportunities
- there has been a change in the person's needs or circumstances
- the person no longer requires support from a HACC volunteer.

In these situations the person should be assisted to transition or exit from the service. Exit from the HACC program is planned with the person according to progress towards their goals or when they require assistance to transition to an alternative program. Before leaving the service, the person should be informed about how they can access the HACC program if required again in the future.

Requirements for volunteer host carer programs

Volunteers play a key role in host carer programs for younger people with a disability. Volunteers in programs such as Interchange provide respite care in both their own homes and in the community, and assist people to attend recreation and leisure activities, camps and other activities of their choice.

Host carers are requested to make a 12-month commitment to provide support. This commitment ensures a consistent and reliable service to support the person and their care relationship. Host caring involves a high degree of responsibility and therefore funded organisations must have detailed documented policies and procedures.

Recruitment and selection

In recruiting a host, the wellbeing of the person, their family and other carers are the primary consideration. The selection process should include a visit by the service coordinator to the home of the prospective host carer to assess the physical environment of the home and to discuss the level of commitment involved.

Volunteer host support

The minimum requirements for supporting volunteer host carers are:

- host carers should have access to adequate training before commencing care and attend at least one in-service each year, in addition to any non-transferable skills training required in relation to their volunteer care role
- host carers must receive quarterly contact by telephone or in person and at least one home visit per year
- host carers should be offered a contribution to expenses incurred, using the volunteer coordination funding specifically designated for the reimbursement of host carer expenses.

Support should be provided to both families and host carers to develop a quality service, including information about other appropriate services. If required referrals can also be made to other appropriate services or for a Living at home assessment.

In supporting host carers, service providers are expected to facilitate activities which engender a sense of community and peer support, such as:

- providing opportunities for host carers and families to share experiences with each other and with their service coordinator
- facilitating opportunities for mutual support structures, such as for host carers to meet each other
- organising guest speakers on topics of interest to host carers and families
- reminding carers and families of the service guidelines.

Training

Use of a cooperative approach to host carer training may be cost and time effective. For example, shared training sessions with shared family care, HACC respite services and other like services.

In some cases, host carers will require non-transferable skills training to meet the needs of a person with complex medical needs. This should be provided by an appropriate health professional.

Matching criteria, process and procedure

The coordinator should endeavour to provide a suitable match between the needs and preferences of the person and their family and the availability and skills of the host carer.

Matching is determined on the compatibility of the person and their family and the host carer, not the person's position on a waiting list or their disability. If more than one person and their family are compatible with a host carer, the match is based on an assessment of each family's relative need for respite as determined by the coordinator.

The minimum matching procedure includes:

- interviewing the person and their family, and potential host carers in their homes
- the provision of information and documentation to the person and their family and to prospective host carers, to enable informed, suitable matching choices
- introductory visits by the person and their family with the service coordinator to the host carers' home or other suitable location, followed by independent discussions with each party to assess suitability.

A 'match' is operational when the person and their family, the host carer and the coordinator agree to the arrangement. A match aims to provide at least one occasion per month of respite care. Requirements above this level are negotiable and there is no obligation for the host carer to provide extra care.

At the coordinator's discretion a family and host carers may have more than one match. Host carers may offer daytime care if that is the preference of the person and their family.

After a match the following documentation is distributed to the person and their family and host carer:

- the joint responsibilities and rights of the person and their family and host carers
- agreement about service arrangements
- the review process and dates.

People requesting a host carer, whether matched or on a waiting list, should receive regular contact from the host carer program. This contact can include visits, telephone conversations, newsletters, invitations to social events and other opportunities for participation.

A match may be ended at the request of the person and their family, or the host carer.

The volunteer coordinator must take action if they believe there are risks to the person's physical, social, psychological or emotional wellbeing. Organisations must have detailed policies and procedures to ensure appropriate practices in such circumstances.

Staffing statement

For detailed information in relation to the qualifications required refer to Part 1: 'Employee and related requirements'.

Reporting requirements

Organisations funded to provide services under volunteer coordination are required to participate in the quarterly collection of the HACC minimum data set (MDS).

There are two kinds of output target for each volunteer program:

- a formal target, linked to funding which specifies the number of hours of paid time by the volunteer coordinator; these hours are reported through the service activity report
- a second target identifies the number of hours of direct contact with service users by the volunteers; these hours are reported in individual client records through the MDS.

For details, see Part 1: 'Reporting and data collection'.

Links

Supporting Volunteers to take an Active Service approach: Resource Kit.
http://www.iepcp.org.au/active-service-model-emr-hacc-alliance or
http://www.oehcsa.org.au/special-project

Flexible service response

Introduction

Flexible service response (FSR) funding aims to enable the development and testing of new, innovative and ongoing approaches to service delivery to ensure a flexible, responsive and evolving service system. FSR funds activities targeted to clients.

Flexible service responses reflect the intention of the active service model and diversity planning and practice to ensure access by priority groups, a focus on person-centred care, capacity building and restorative care in service delivery.

The FSR funding category is used to resource new, evolving and ongoing service delivery models, that are in addition to the standard HACC service types. For example:

- activities, developmental projects or trials designed to test and evaluate new or innovative service delivery models and approaches for specific groups of HACC-eligible people
- activities or approaches which have developed beyond projects to become ongoing services in addition to other HACC service types. For example: support for Aboriginal people to attend important cultural gatherings such as funerals.

Scope

FSR arrangements must be negotiated and mutually agreed between the Department of Health regional office and the funded organisation. The arrangement will be reviewed over time to determine whether the service or approach can be accommodated within a particular HACC activity or whether it should remain under the FSR category.

Staffing statement

Staff delivering programs or activities funded through flexible service response (FSR) must hold the relevant qualifications as outlined in Part 1: 'Employee and related requirements'.

Reporting requirements

Agencies funded for FSR will report direct client service delivery through the HACC MDS using the relevant activity type (for example personal care, if the FSR funds went into the delivery of personal care).

Agencies will report any other activity through the service activity report as negotiated with the regional office.