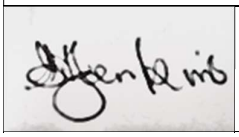
Date approved	27/6/22
Previous titles	Access to Services 21/9/18, Aged Services: Access to CHSP Services 27/9/21
Previous versions	N/A

Signature by Management representative	
	Chairperson, Suzanne Jenkins

AGED SERVICES: SUPPORT PLANNING POLICY

Internal ECS References	
In S:\0 CURRENT POLICY & PROCEDURES:	***In S:\1 CURRENT FORMS:***
Aged Services: CHSP Compliances Policy	*Fit to Attend Social Groups questionnaire*
Aged Services: Access to Services Policy	*Fit to Attend Exercise questionnaire, Letter to Medical Practitioner*
Planning & Evaluation Policy	*Aged Services Client Information Form*
	Wellness and Reablement Support Plan
	S:\0 current data base
	S:\2 BROCHURES & FLYERS
	Information About ECS Activities in S:\2 OFFICE SYSTEMS
	S:\2 current AGED SERVICES TEAM

External References	
https://www.health.gov.au/resources/publications/commonwealth-home-support-programme-chsp-manual	*Aged Care Quality Standards at https://www.agedcarequality.gov.au/providers/standards*
https://www.health.gov.au/resources/publications/commonwealth-home-support-programme-guidelines	
https://www.myagedcare.gov.au	

Table of Contents

1. POLICY STATEMENT

ECS is committed to providing high quality services through the development and maintenance of client-centred support planning and review.

1.1 Definitions

client = term used across ECS programs and policy documents instead of "consumer", which is specific to Aged Care
My Aged Care = gateway to Australian Government Aged Care services, comprising of a call centre, website and assessors, using standardised tools and client records and linked to providers through an online Service Provider Portal
reablement approach = a planned approach to community care and services for older people that aims to help them re-establish daily living skills and community connections through a time limited, goal-oriented program
wellness approach = listening to what the client wants to do, looking at what they can do (their abilities) and focuses on regaining or retaining their level of function and minimising the impact of any functional loss so that they can continue to manage their day to day life

1.2 Acronyms

CHSP = Commonwealth Home Support Programme [Australian Government Aged Care funding received by ECS[
ECS = Engadine Community Services

2. GENERAL POLICY

ECS provides a support plan for each Aged Services client, based on their agreed needs, goals and preferences for Social Support service/s of the type provided by the organisation. These services are individual and group supports. Support planning involves assessing the individual's preferred service type, their ability to participate and the meeting of their needs as assessed by My Aged Care. Support Plans are reviewed annually.

3. ASSESSMENT & SUPPORT PLAN DEVELOPMENT

3.1 Accepting a New Client

On receipt of a My Aged Care referral for a named client (see ***Aged Services: Access to Services Policy***), the Aged Services Co-ordinator reads the assessment thoroughly to determine the person's eligibility and suitability for ECS services, taking into consideration:

- level of service required (with consideration of duty of care and risk)
- medical conditions
- cognitive health
- mobility
- suitability for service provided by a volunteer

The client is then contacted by phone, and their desire for services confirmed. The Aged Services Coordinator seeks an appointment to visit the client at their home for a Service Level Assessment if their My Aged Care referral contains any of the following:

- request for ECS Social Support: Individual [see below] services other than Friendly Phone Calls
- request for ECS Social Support Group [see below] services other than Computers for Seniors

If the client does not want another in-home assessment, the Aged Services Coordinator may make an appointment to meet the client in the ECS office for a Service Level Assessment, but not if their My Aged Care referral contains any of the following:

- elements that raise WHS questions or concerns
- request for ECS services involving the client entering an ECS vehicle or Home Visits [see below]
- a cognitive health condition, such as dementia, where a family carer needs to be present

3.2	Service Level Assessment

The client is encouraged however to have the support of whomever they wish during the assessment; however, the Aged Services Co-ordinator addresses the client, indicating that the clients is in charge of their own support planning partnership with ECS.

At a face-to-face assessment, particulars of service needs and wants are discussed, with particular consideration of the client's mobili*ty*. Self-assessments are used to assist the client to choose from available options and for the Aged Services Coordinator to agree to provide safely from the following services:

Service Type	ECS Name	Occurrence	Description	Support and benefit to the older person
Social Support: Individual	Friendly Phone Calls	Weekly, fortnightly or monthly [Tues] + occasional	In-home + Centre-based	Support clients who live on their own or are limited in their mobility and providing support through COVID-19 Stay at Home orders.
Social Support: Individual	Home Visiting	As required	In-home	Support clients who live on their own or are limited in their mobility.
Social Support: Individual	One-on-one shopping/ community access	As required	Community-based	Support with transport and mobility to complete shopping and appointments for the older person.
Social Support: Individual	Computers for Seniors	As required [Mon]	Centre-based	Provide older people with learning support to stay connected and to be able to make appointments and access services as needed.
Social Support: Group	Men's Social Group Social Craft Group Cards for Seniors	Fortn.ly [Tues] Wkly [Wed] Wkly [Fri]	Centre-based social group	Provide an opportunity to connect with others, improved mental health and decreased isolation.
Social Support: Group	Social Bus [shopping]	3x monthly [Wed]	Outing with transport	Provide a social activity, an outing to look forward to, with a lunch as part of the outing. Support with transport and mobility assistance where needed.
Social Support: Group	Parkinson's Fitness Group SeniorCise Seniors' Fitness Group Tai Chi	2x wkly [Mon] 3x wkly [Tues, Thur] Wkly [Mon] Wkly [Thur]	Centre-based social exercise group	Regain and enhance mobility, maintaining physical abilities and prevention of falls due to improved balance and muscle tone.
Social Support: Group	Social Bus [Friendship/Big Day Out]	Occasional	Outing with transport	Provide a social activity, an outing to look forward to, with a lunch as part of the outing. Support with transport and mobility assistance where needed.

Depending on services requested, the client may be asked for specific information from a medical professional, such as a letter detailing any physical limitations or risks, and any equipment requirements [eg. oxygen, mobility devices]. This information is added to their *Client File* and the *ECS Data Base* for quick access, as well as the *Wellness and Reablement Support Plan* [below].

Requests for group types which are not currently provided by ECS are submitted to future service planning [see ***Planning & Evaluation Policy***].

3.3	Documentation

A *Wellness and Reablement Support Plan* detailing client's expressed needs, goals and preferences is completed with them. ECS provides all documentation and conversations with clients in plain, simple English. An interpreter is offered, where appropriate. Each client signs their completed plan and is issued with a copy of it.

In the development of the plan, a Yes/No question in regard to the existence of an Enduring Guardianship and Enduring Power of Attorney is completed, but due to the low level services provided by ECS, Advanced Care Planning is not discussed with the client.
Each client is treated as an individual, although support plans for clients with similar profiles may contain common phrasing for goals and outcomes, such as:

- maintain independence
- increase fitness
- increase mobility
- improve social interactions

The assessment may also inform the creation of specific safety plans and resources utilised for each client specific safety plans and resources utilised for each client [see *Aged Services: Client Files Policy*]. For instance, in the case of clients who require an oxygen tank, a volunteer should be briefed based on a written instruction from the client's medical practitioner in regard to transporting the oxygen and how long the client can be safely off the oxygen tank.

4. MONITORING & REASSESSMENT

Ongoing monitoring of the plan includes recording any changes, incidents, complaints and positive feedback, and successes or improvements in the client's wellbeing.

The *Wellness and Reablement Support Plan* is updated annually, by telephone or in person. The plan is also updated in response to a request, or due to a change in client circumstances or health condition impacting their safety or that of others at ECS, such as volunteers providing service or other clients in groups. If the client is lacking insight into the situation [eg. behaviour problems due to dementia], a carer may be required for these discussions.

A copy of the updated plan is signed by the client, as well as a second copy for them to keep. At the time of signing, the client is asked to confirm their understanding of each new or altered document before signing, and encouraged to ask questions if unsure of any contents.