

SUGGESTED DUTIES FOR HACC WORKFORCE IN SUTHERLAND SHIRE

FOR EACH HACC SERVICE TYPE DESCRIPTION



HACC SERVICE TYPE (per HACC <i>Service type descriptions 2008</i>)	PAID WORKER DUTIES	VOLUNTEER DUTIES (excluding committee level)
<p>DOMESTIC ASSISTANCE 10.01 = assistance with domestic chores, including assistance with cleaning, dish washing, clothes washing & ironing, shopping & bill paying for a safe secure healthy environment</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - cleaning of bathrooms, toilets, kitchens, laundries, living areas & bedrooms - cleaning stoves, bench tops & fridges, mopping or vacuuming floors, dusting, dishwashing, changing bed linen, washing, drying & essential ironing (not window cleaning etc = low home maintenance) - assist with meal preparation - [not primary purpose] unaccompanied shopping (list grocery shopping only); undertake small errands & pay bills on behalf of the client 	
<p>SOCIAL SUPPORT 10.02 = assistance provided by a companion (paid worker or volunteer), either within the home environment or while a person is accessing community services or facilities = primarily directed towards meeting the person's need for social contact &/or accompaniment in order to participate in community life</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - liaison with carers - management of service to ensure maximum, effective use of resources, including human resources - recruitment & training of volunteers & matching volunteers to individual client circumstances - service delivery duties (listed on right) when volunteers are not appropriately skilled to meet the client's complexity of needs (eg. dementia, difficult behaviours, physical support) 	<ul style="list-style-type: none"> - one to one support to attend a social activity of the consumer's choice - supported involvement with a small group of people, incl outings & day trips - telephone-based monitoring services & friendly visiting - meal assistance - letter writing for the client - accompanying individual clients to appointments & social activities, incl shipping, banking & bill paying - minor garden & home maintenance & domestic tasks (eg. changing light globes)
<p>SOCIAL SUPPORT MONITORING 10.02 = services which monitor the health & well-being of people who have dementia or are recovering from hospitalisation or are at risk of injury = provides feedback to case managers about other support services being provided for individual clients = to maximise the ability of individuals to remain living independently at home & assist meeting the person's need for social contact</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services, incl referral to ACAT for comprehensive assessment when required - provision of information regarding other services - liaison with carers - management of service to ensure maximum, effective use of resources, including human resources - monitoring the health & well-being of people living alone via regular visits - management of telephone based monitoring & personal alarm systems - implementation of the monitoring plans or informal alternatives - monitoring a client's self management of medications - personal care - prompting the client to eat - assistance with management of appointments & planning daily activities 	<ul style="list-style-type: none"> - provide companionship, social support - prompt client to eat and plan meals - advise coordinator of any changes in client needs/general wellbeing - assist with planning daily activities (Duties do not include medication monitoring, domestic or personal care assistance or any lifting)

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<p>ALLIED HEALTH GENERAL 10.03 =professional services for Podiatry, Physiotherapy, Occupational Therapy, Speech Pathology & Dietetics</p> <p>ALLIED HEALTH-PODIATRY 10.04 =diagnosis & treatment, by medical, surgical, electrical, mechanical or manual methods, of ailments or abnormal conditions of the feet</p> <p>ALLIED HEALTH PHYSIOTHERAPY 10.05 =assessment, diagnosis, treatment & prevention of disorders of human movement with special emphasis on the neurological, musculoskeletal & cardiovascular systems</p> <p>ALLIED HEALTH SPEECH PATHOLOGY 10.07 =assessment, diagnosis & treatment of individuals with speech disorders, eating & drinking difficulties & swallowing difficulties</p>	<ul style="list-style-type: none"> - clinical assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - treatment - therapy - information - assessment & recommendation for the provision of aids & modifications to the home 	
<p>ALLIED HEALTH OCCUPATIONAL THERAPY 10.06 =assessment & treatment through the specific use of selected activity designed by the occupational therapist undertaken by those who have a temporary or permanent disability =aims to prevent disability, to improve health & to help the person to fulfil his or her needs by achieving optimum function & independence</p>	<ul style="list-style-type: none"> - clinical assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - research & maintenance of evidence base for recommendations, incl liaison with Home Modifications Clearing House - treatment - therapy - information - assessment & recommendation for the provision of aids & modifications to the home - Occupational Health & Safety 'workplace' assessment of clients' homes where this is required & otherwise unavailable - liaison with clients, builders & architects for recommended home modification 	

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<p>ALLIED HEALTH DIETETICS 10.08 =all aspects of the food & nutritional care of individuals & groups =assists people to meet their individual needs within their own psychological, cultural & economic environments</p>	<ul style="list-style-type: none"> - clinical assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - treatment - therapy - information - assessment & recommendation for the provision of aids & modifications to the home - liaison with HACC meals on wheels & other food services - support appropriate planning of food services or meal preparation activities - facilitate funded food services & other non-government community organisations to access dietetics advice 	
<p>NURSING 10.09 =professional nursing care provided by a registered or enrolled nurse who is employed in a nursing capacity =provided either at home, in a community venue or in a clinic =not an emergency service and cannot substitute a doctor = shared care arrangements with Personal Care providers may include training & supervising PC workers</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - teaching individuals & carers how best to manage daily care in the home environment - provision of information on general health care & giving advice on the management of particular health problems such as diabetes & incontinence - direct clinical nursing care based on the nurses' level of qualifications - personal care for consumers where provision by a nurse is required due to particular health conditions, unstable health &/or complex needs - supervision & training of health aides & personal care workers providing direct care - provision of health information & education - co-ordination of home health care services & monitoring of an individual's health status &/or care plan 	

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<p>PERSONAL CARE SERVICES 10.10 =daily self-care tasks in order to help a service user to maintain appropriate standards of hygiene & grooming =services must be flexible to match client's lifestyle requirements, including provision outside standard business hours =not for children under 6 years, when most personal care tasks are considered normal parental care</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services, including - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - assistance with (or supervision of) bathing, showering or sponging, dressing and undressing, shaving, hair care & grooming - limited nail care, following appropriate professional assessment (observe only and refer appropriately) - assistance with mobility (in/out of bed) such as to sit up, to turn, to stand & walk, to sit, to transfer to commode, wheelchair, chair or vehicle - assistance with toileting - assistance with prescribed exercise or therapy programs - assistance with fitting & use of appliances such as splints and callipers or hoists - assistance with hearing aids & communication devices - assistance with feeding (eating & drinking) if it occurs whilst other personal care services are being provided - monitoring self-medication - identification of situations such as pressure areas & ulcers, where referral to a nursing service is required 	
<p>CENTRE-BASED DAY CARE 10.11 =assistance to the client to attend/participate in group activities conducted in a centre-based setting, including excursions conducted by centre staff but held away from the centre =social support in a group environment and light refreshments, excursions incl. transport, & personal care involved in attendance at the centre</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services, incl referral to ACAT for comprehensive assessment when required - provision of information regarding other services - liaison with ACAT & carers - management of service to ensure maximum, effective use of resources, including human resources - personal care (eg assistance with toileting) - provision of a meal & assistance with eating - organising activities: music therapy, allied health care (eg. health education), outings & day trips - (where Transport is funded separately: provision of transport for clients & trip-related parcels/equipment to/from CBDC, co-ordinating modes & support matched to client need including wheelchair accessible vehicles, provision of assistance including to/from vehicle & waiting with the client at their destination for individual transport; assets management of vehicles) - recruitment & training of volunteers 	<ul style="list-style-type: none"> - provision of transport to & from Centre (not with complex care clients at Southcare) - providing range of activities (eg. Southcare provide hand massages, if Red Cross trained) - help with food service & support for individual clients (not with complex care clients at Southcare) - (where Transport is funded separately: provision of transport for clients & trip-related parcels/equipment to/from CBDC, , provision of assistance including to/from vehicle & waiting with the client at their destination for individual transport)

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<p>CENTRE-BASED DAY CARE WHEN APPLIED TO PEOPLE WITH DEMENTIA 10.11 =structured group activities to people with dementia, designed to develop, maintain or support the capacity for independent living & social interaction which are conducted in a day centre setting = provide valuable social supports to people with dementing illnesses & their programs often directly or indirectly provide emotional support to the carers of people with dementia</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services, incl referral to ACAT for comprehensive assessment when required - provision of information regarding other services - liaison with ACAT & carers - management of service to ensure maximum, effective use of resources, including human resources - personal care (eg assistance with toileting) - provision of a meal & assistance with eating - organising activities: music therapy, allied health care (eg. health education), outings & day trips - (where Transport is funded separately: provision of transport for clients & trip-related parcels/equipment to/from CBDC, co-ordinating modes & support matched to client need including wheelchair accessible vehicles, provision of assistance including to/from vehicle & waiting with the client at their destination for individual transport; assets management of vehicles) - recruitment & training of volunteers 	
<p>MEALS 10.12 =preparation and delivery of meals or other food items which contribute to meeting a client's daily nutrition requirements =delivered fresh daily or frozen for re-heating at the client's convenience =delivered to a client's home or be provided in a group environment such as centre-based day care or community restaurant</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - packing, sorting & stocktake of a range of meal types - ensuring access, wherever possible, to a range of different meal types including culturally appropriate, vegetarian meals & meals which meet specific dietary requirements - monitoring of client's well being & referral to other services - providing meal choices from a regularly changing menu 	<ul style="list-style-type: none"> - assisting paid staff in packing, sorting & stocktake of meals & produce - provision of social contact - deliver meals to clients who do not have complex needs - heating & plating the delivered meal ready for the client to eat & cleaning up afterwards - prompting or assisting with eating & drinking if not part of a personal care service
<p>OTHER FOOD SERVICES 10.13 =support activities which contribute to the client's capacity to meet their daily nutritional requirements</p>	<ul style="list-style-type: none"> - <i>initial assessment & care planning, regular review & re-assessment of the client's needs</i> - <i>formal referral to other services</i> - <i>provision of information regarding other services</i> - <i>management of service to ensure maximum, effective use of resources, including human resources</i> - <i>assistance with the preparation & cooking of food in the client's home</i> - <i>provide advice about nutrition, menus & special diets, information about food handling & storage</i> - <i>bulk food shopping which is distributed to individual clients & storing it at the client's house</i> 	<ul style="list-style-type: none"> - provide range of training, such as cooking classes; Volunteers could be sourced from trained food tech or hospitality staff - serve meals in café type food services

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<p>RESPIRE 10.14 =substitute carer who provides supervision & assistance to the care recipient (even though the carer may still be present) incl. personal care, meal preparation, domestic tasks, overnight stays =provided to carers to give relief from their caring role =designed to be responsive to the carer's needs ie. the carer is the principal client =preventative in focus, time limited, & generally provided on a planned basis =provided from the home of the care recipient or in a host family home =provided on a one to one individual basis =service planning in collaboration with care recipient & carer/family to ensure all needs are met, incl. care recipient's supports</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - management of service to ensure maximum, effective use of resources, including human resources - scoping, costing, coordinating, planning &/or purchasing agreed services as appropriate - personal care - meal preparation & domestic tasks - overnight stays if needed - where services are to be sub-contracted, monitoring the quality, cost & amount of service purchases on behalf of service users & ensuring that all the responsibilities from the Funding Agreement, & legal liabilities are fulfilled 	
<p>CASE MANAGEMENT 10.15/COMMUNITY OPTIONS (COPS) MODEL =client focussed model process for managing a client's support, care & social health needs if they <i>-have interacting physical/medical, social & emotional needs (ie complex needs) & require comprehensive assessment & formal case management</i> <i>-need short-term, ongoing or periodic case management to organise & co-ordinate community care services</i> <i>-needs can rapidly change & who need a case manager to monitor their situation & ensure a quick & flexible service response when needed</i> <i>-need specific types, mixes or levels of support services not usually provided by community care services & need a case manager to help organise them (can be due to their ethnic or Aboriginal background, dementia or geographic isolation)</i> <i>-the carers of these people</i> =collaborative process of screening & assessment, care planning, implementation, monitoring & review, case closure =care plan implementation may include provision of direct and brokered service (incl one-off purchase or lease one-off goods or services with quality of life benefits & not available through PADP & support services not usually available from the community care network but meet the HACC case management project's duty of care obligations) =brokerage funds can purchase regular HACC services for up to 3 months with review when the client is eligible for the service but service is unavailable due to funding, the client is in danger of premature institutionalisation in the absence of service while on a waiting list or services have been suspended</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - screening & Comprehensive Assessment that includes intake & referral activities - specific case management activities: Care Planning; Care Plan Implementation which includes provision for both direct service delivery & brokerage; Monitoring & Evaluation; Case Closure & Exit 	

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<p>HOME MODIFICATION 10.16 =structural changes to the client's home (incl gardens & yards) so they can continue to live & move safely about the house =not general repairs but explicit changes to improve safety or accessibility</p> <p>(NB – interim service model applies during transition to meet new licensing compliances: Level 1 to \$7,500, Level 2 \$5,000-\$25,000, Level 3 over \$20,000)</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - liaison with other HACC providers to ensure provision of a safe home for clients, carers & care-workers - liaison with appropriate allied health providers, principally OTs - scoping, costing & planning modification work, sourcing appropriate materials & suitably qualified tradespeople & handypersons - establishing payment arrangements with the client - providing bathroom modifications (eg. grab rails, replace bath with hobless shower, re-locate toilet), kitchen modifications (eg. lowering benches for wheelchairs, replacement of ovens), access modifications (eg. ramps, widening doorways), electrical modifications (eg. re-siting switches) - installation of emergency alarms & other minor modifications - providing some major dwelling modifications, such as the redesign of a bathroom or kitchen or converting a garden to low maintenance 	
<p>HOME MAINTENANCE 10.17 =maintenance & repair to the home, gardens & yard to help client to cope with a disabling condition & to keep the home safe & habitable =does not cover structural changes but include modifications/adjustments to furniture or fittings to improve ease of use & safety</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services & provision of information - management of service to ensure maximum, effective use of resources, including human resources - liaison with other appropriate allied health providers, principally occupational therapists, & HACC providers to ensure provision of a safe home for clients, carers & care-workers - scoping, costing & planning maintenance & modification work, sourcing appropriate materials & suitably qualified tradespeople - facilitating access to qualified tradespeople to carrying out minor dwelling repairs & maintenance & carrying out minor household repairs which do not require the skills of a qualified trades person: providing minor carpentry (eg. windows, doors, floors, cladding, security devices), minor plumbing/drainage (eg. washers, cisterns, minor leaks), other plumbing (eg. Installing hot water supply, replacing unsafe guttering), minor electrical (eg. Fuses, light globes, replacing switches), other electrical (eg. Replacing hot water heaters) - external maintenance (eg. fences, paths, one-off removal of rubbish & major clean-ups, especially in bush-fire prone areas), repair of appliances, fittings & furniture (eg. chair backs), other maintenance (eg. plastering, bricklaying, painting, chimney cleaning), regular lawn mowing or other garden upkeep - clean-ups of house & garden to enable a HACC service to commence - garden re-design to improve accessibility & to provide ease of maintenance for the service user 	

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<p>FORMAL LINEN SERVICE 10.18 =provision of & laundering of linen, usually by a separate laundry facility or hospital, to assist in the day-to-day management of a client's incontinence</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - purchase of linen for provision to clients (sheets, pillowslips, blankets etc) - collection, laundering & delivery of fresh linen - other clothes washing or laundering, airing & cleaning mattresses 	
<p>TRANSPORT 10.19 =transport & support to access to community activities & services =provided directly or indirectly (eg, taxi voucher or subsidies, or brokered through other transport providers) =provided on group (to CBDC or Social Support activity group) or individual basis (to doctors or other medical appointments) =NOT for employment, education, training options or early intervention/children's programs</p> <p>NB – organisations with vehicles carrying eight or more passengers must be an accredited operator under NSW Ministry of Transport's Community Transport Accreditation Standards</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - operation of telephone booking service - coordination of client bookings, matching client need with the most appropriate transport mode & support - organisation of group trips, including culturally appropriate social trips & shopping services with access to a range of options (retail, banking, postal, library) - asset management of vehicles including lease, purchase, modification of vehicles (incl wheelchair accessible), maintenance and replacement 	<ul style="list-style-type: none"> - provide office assistance in areas of filing, banking, driving vehicles for maintenance checks, driver familiarisation of vehicles - provision of client assistance (for clients who do not have complex needs) to/from the vehicle, on vehicle assistance during group trips, & possible waiting with client at their destination - safe carriage of trip related to parcels &/or equipment. - training clients in use of public transport systems incl assistance with routine trips to give confidence to clients
<p>GOODS AND EQUIPMENT 10.22 =loan or purchase of goods & equipment that help the client with their mobility, communication, reading, personal care or health care</p>	<ul style="list-style-type: none"> - initial assessment & care planning, regular review & re-assessment of the client's needs - formal referral to other services - provision of information regarding other services - management of service to ensure maximum, effective use of resources, including human resources - provision of walking frames, wheelchairs, commodes or dressing aids - referral to the Program of Appliances for Disabled People (PADP) where appropriate 	

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CLIENT CARE CO-ORDINATION 10.23 =coordination of activities undertaken to facilitate access to HACC services for clients who need help to gain access to more than one service =client can be either the person who is cared for or the carer =services can be provided separately or combined	<ul style="list-style-type: none"> - liaison with service providers & assessment agencies dealing with the same client - advocacy to ensure that the client has access to the range of services required - monitoring & reviewing the case or service plan on a regular basis - monitoring care plans to respond to crisis situations - re-assessment & implementation of transition plans as required
ASSESSMENT 10.24 (& re-assessment) =activities of eligibility & access to services that are directly attributable to individual care recipients =must necessarily be done with the full involvement of the client as well as family members or carers	<p>Four elements in conjunction or separately:</p> <ol style="list-style-type: none"> 1. Assessment for eligibility is the matching of client characteristics against program & agency guidelines. Depending on the extent or clinical nature of these guidelines, this might be done at the initial contact point or by designated assessors or clinicians. Related activities will include: <ul style="list-style-type: none"> - Determination of eligibility for service provision by matching of client characteristics against program & agency guidelines. 2. Assessment for support needs is divided into two parts, the first being a means of identifying need in broad terms, but without depth of investigation. This is an initial screening process. It may be followed by more in-depth assessment. Taken together, these two levels of assessment identify the range of appropriate potential response options. Related activities will include: <ul style="list-style-type: none"> - Completion of the Functional Screening Tool. - Undertaking service level or comprehensive assessment as required, using current best practice tools. 3. Assessment for service response refers to the identification of proposed service delivery. It may include case planning. Related activities will include: <ul style="list-style-type: none"> - Development & coordination of services identified in Assessment Element 2 (identification of support needs) - Development of care plans - Identification of occupational safety & health issues - Referral to more appropriate programs for clients needing more than basic support services or specialist assessments & programs. 4. Priority allocation is not a separate assessment process, but an outcome of an analysis of the combination of the needs & risks associated with a given client. Activities will include: <ul style="list-style-type: none"> - Within an identified targeting strategy, allocation for service priority relative to other prospective service users. <p>It is expected that assessment will take place, where required, in conjunction with an Aged Care Assessment Team (ACAT) & /or other assessment agency</p>

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NON-OUTPUT SERVICES 10.20 ABORIGINAL HACC ACCESS/DEVELOPMENT OFFICER =will work with the service provider network (both Aboriginal specific & mainstream) & local Aboriginal communities to identify gaps in services for Aboriginal people in the designated Area	Provision of an annual workplan to funding body by mid October & report on previous year's activities: <ul style="list-style-type: none"> • Develop initiatives to enable the Aboriginal community to acquire knowledge & access to the HACC service system • Research & remain up-to-date with the needs of the local Aboriginal HACC target Population • Facilitate service development in the provision of HACC services to the Aboriginal Community • Establish, maintain & participate in networks, partnerships & links within & across relevant sectors • Participate in relevant policy development processes where appropriate 	
NON-OUTPUT SERVICES 10.20 AGED & DISABILITY OFFICER =jointly funded by DADHC & Local Government to develop, promote & facilitate relevant strategies & activities at the local level focused on outcomes for the HACC target population	Provision of an annual workplan to funding body by mid October & report on previous year's activities: <ul style="list-style-type: none"> -Provide information about the HACC Program & the services it offers -Establish, maintain & participate in networks, partnerships & links within & across relevant sectors -Facilitate the inclusion of the HACC target population & special needs groups, in local activities & local consultation processes -Support & be a resource for local HACC networks -Share & disseminate good practice initiatives & research -Collate views & information from the HACC target population where appropriate, to peak & government agencies to improve the service system -Participate in relevant policy development process -Contribute to Local Government activities for the HACC target population -Provide advice & assistance to relevant working groups such as Access Committees -In collaboration with any other development worker(s), contribute to project & service system planning by identifying shared goals & complementary strategies -Facilitate service development in the provision of HACC services 	- membership of working groups & organising events
NON-OUTPUT SERVICES 10.20 MULTICULTURAL ACCESS PROJECT =assists with capacity building in HACC to meet CALD clients' needs	Provision of an annual workplan to funding body by mid October & report on previous year's activities: <ul style="list-style-type: none"> -Provide advice, information & assistance to the HACC services (as appropriate) to strengthen &/or develop their policies &/or activities in order to achieve higher quality outcomes for CALD HACC service users -Only select the activities (& add any new activity) that best suit or reflect the current local needs, priorities & the size of funding of each individual Multicultural Access Project -Develop/implement initiatives to build greater awareness of HACC services among CALD HACC population groups -Conduct consultation & research as appropriate to identify/ ascertain & document the needs of the local CALD HACC target population -In consultation with DADHC, facilitate HACC service development opportunities for CALD HACC target population -Facilitate, contribute to, & participate in relevant HACC policy making &/or planning processes -Identify, document, share & disseminate good practice initiatives & research reports relating to the CALD HACC community -Undertake/participate in the development & dissemination of resource materials for CALD communities -In collaboration with DADHC &/or other stakeholders, promote the use of interpreting & translating services by HACC services -Participate in & contribute to the Multicultural Access Projects Network meetings -In collaboration with other relevant stakeholders, develop/contribute to partnership projects for the interests of the CALD HACC target population 	

	<ul style="list-style-type: none"> - Establish, maintain & participate in relevant networks & initiatives within & across relevant sectors, for the interests of CALD HACC target populations 	
<p>NON-OUTPUT SERVICES 10.20 HACC DEVELOPMENT OFFICER =provides a range of support, resource & information services to HACC-funded agencies & other organisations providing for the benefit of the HACC target group</p>	<p>Provision of an annual workplan to funding body by mid October & report on previous year's activities:</p> <ul style="list-style-type: none"> -Inform current & potential service users, relevant government agencies, health, community care, disability service providers & the community about the HACC Program & the services it offers -Build & generate social capital through establishing, maintaining & participating in networks, partnerships & links within & across relevant sectors -Support & be a resource for local HACC networks & individual HACC funded agencies -Provide information to HACC funded agencies on Program policies & guidelines such as the HACC National Guidelines, the HACC Service Standards, referral & assessment protocols & reporting requirements such as quarterly MDS reports -Support & inform HACC-funded agencies on policy implementation & policy changes, in partnership with DADHC regional staff -Support groups of HACC services that wish to consolidate their activities in order to achieve greater efficiency or higher quality services -Share & disseminate good practice & local, state, national & global initiatives & research -Promote better practice towards a cohesive community care sector -Assist with identification & prioritisation of regional needs through the regional planning processes -Collate views & information from service users & providers to peak & government agencies to improve the service system -Provide governance information, including addressing management committees & participating in organisational planning days -Participate in relevant policy development process -Facilitate HACC funded & related community care agencies' access to appropriate information, resources & relevant training -In consultation with DADHC, develop strategies to identify & address the training needs of HACC-funded organisations -In collaboration with any other development worker(s), contribute to project & service system planning by identifying shared goals and complementary strategies 	
<p>COUNSELLING/SUPPORT, INFORMATION & ADVOCACY 10.25 =assistance with understanding & managing situations, behaviours & relationships associated with the person's need for care &/or the caring role =client can be either the person who is cared for or the carer</p>	<ul style="list-style-type: none"> - Provision of initial counselling such as grief counselling, dementia support & counselling, counselling to assist recovery from a critical incident or illness, referral for professional counselling for depression or long-term emotional & psychological conditions - One-to-one training or advice to assist with coping with a situation, ie. training a carer on safe ways to lift a person or managing challenging behaviours in a client with dementia\ - Provision of information to a client or a carer, I e. information about other services available in the area - Provision of advice to clients about their rights & responsibilities when receiving HACC services &, at the client's request, to act on their behalf with other service providers 	