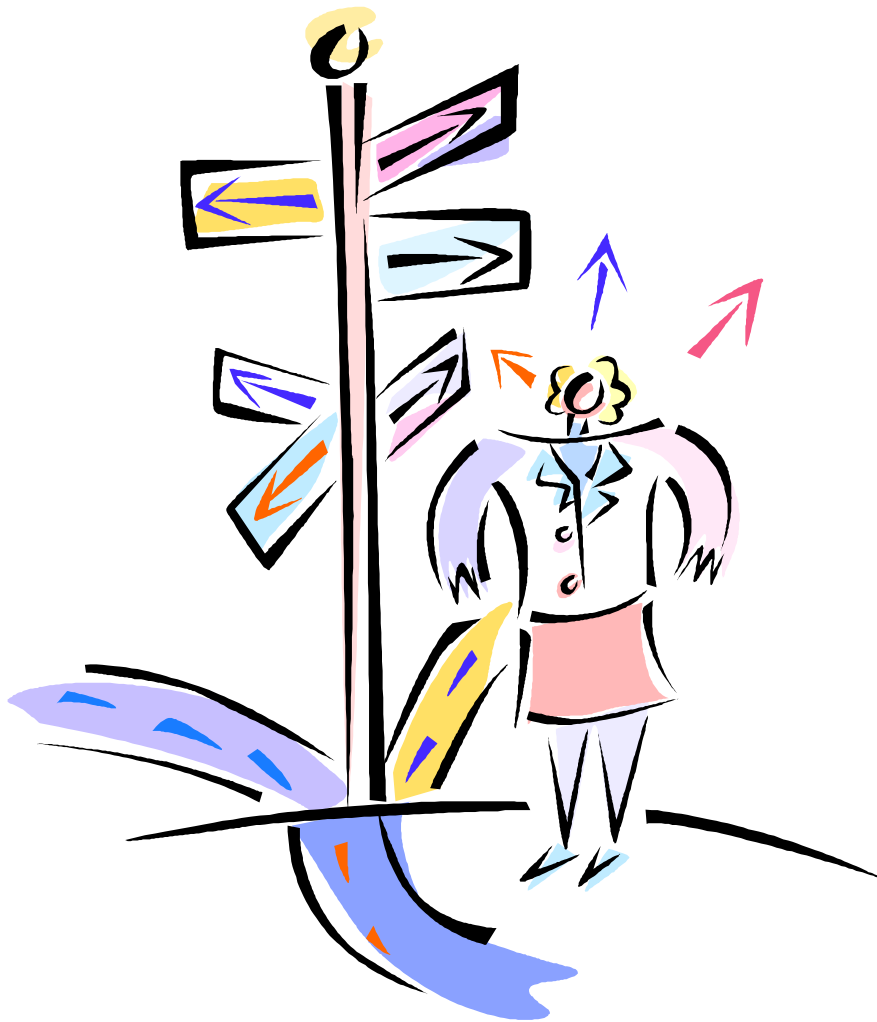


*Co-ordination Protocols for the Continuity of
Care for Clients receiving Personal Care in
Newcastle/Lake Macquarie HACC Region.*



*Developed by the Newcastle/Lake Macquarie HACC Support
Project in conjunction with Baptist Community Services, Mercy
Community Services and Home Care-Greater Newcastle Branch.*

Developed July 2005, to be reviewed February, 2006.

*Co-ordination Protocol for the Continuity of Care for
Clients receiving Personal Care in
Newcastle/Lake Macquarie HACC Region.*

This protocol is in response to concerns about changes of service providers occurring during the care support period for the HACC target group and how the Home and Community Care funded services can improve on working together, maintaining the fundamental principles of co-operation, collaboration and consumer participation.

Services included in this protocol are service providers delivering personal care services in the Newcastle/Lake Macquarie LGA's such as:
Dept. of Ageing, Disability & Home Care, Home Care – Greater Newcastle Branch
Baptist Community Services
Mercy Community Services.

For the purpose of this protocol Home Care Branch, Mercy Community Services and Baptist Community Services will be referred to as Community Service Providers.

1. PRINCIPLES

- That it is of vital importance to co-operate and communicate in an effective manner to achieve a high standard of client outcome.
- To, as dictated by the Newcastle/Lake Macquarie CIARR Protocols, supply written confirmation of receipt of referral and assessment.
- To inform clients and their carers of the current available options for services at this time of high level need support.
- To offer to refer and seek for the client and their carer extra support services as required.

2. REFERRAL PROTOCOL.

2.1 Confidentiality

The parties recognise the statutory and ethical duties of confidentiality applying to community workers and therefore agree that no information will be provided to services without consumer consent with the following exceptions.

- In an emergency situation where the community worker has reasonable ground to believe that the physical health of the consumer or members of the public is at serious risk.
- Any information provided under this protocol shall be provided on a confidential basis subject to the legal obligations of workers in each service under the Privacy and Personal Information Protection (PPIP) Act 1998 (NSW).

2.2 Duty of Care.

“Duty of Care” as a concept is part of the larger legal concept of negligence. There is no precise legislated definition for concepts such as “Duty of Care” and “Negligence”.

A duty of care exists when someone’s actions or omissions could reasonably be expected to affect other people. The standard to which a given activity must be performed to meet the duty of care is the standard, which a reasonable person would try to meet.

Under HACC Standards all services must have policies and or protocols that relate to “Duty of Care”.

2.3 Referral Process

- a. The basis for referral will be the CIARR
- b. Additional relevant health information may be included in a Client Care Plan.
- c. Where necessary, joint visits may have to be initiated.
- d. The request for additional assistance and the client’s eligibility for that additional support will be confirmed within 5 working days.
- e. If no extra support services are available the client will immediately be referred for Comprehensive Assessment (high care needs) as per the National Functional Screening tool.

When to Refer

1. There is concern regarding the ability of the community providers to meet the clients needs, which may be indicated by;
 - a. A sudden deterioration in the client medical condition.
 - b. Cognitive and or memory impairment suspected of adversely influencing the person’s capacity to make rational decisions.
 - c. Signs of neglect including self neglect. For example evidence of social isolation, poor hygiene, poor diet, diminished awareness, and diminished awareness of financial situation and disorientated wandering.
 - d. Signs of abuse. (as per Hunter Abuse Protocol)

Joint participation to plan and review co-ordination of care is indicated by any of the above.

Relevant Information to be provided on referral

- Client details (name of Primary Carer)
- GP details
- Legal status if known
- Reason for referral
- Observation of behaviour/appearance
- Current medications
- Current medical problems
- Urgency/Level of risk
- Is the client, GP, next of kin, primary carer aware of the referral

3. EMERGENCIES

Occasionally clients may require unexpected extra services (e.g. client is sick/incontinent during the night and service not due for another day). Services will encourage clients who are likely to find themselves in these situations to have an "Emergency Plan". This emergency plan may include assistance from friends/family or service providers.

Each of the services is involved with the client to develop a plan for Unexpected Extra Service needs. If the client has no other support mechanisms it may be appropriate to refer them to a PRIVATE SERVICE PROVIDER or an ambulance in an emergency.

4. FEES

Fees should not be a driving factor regarding referral as all HACC Providers must "determine the client's ability to pay". No service will discuss the charges of other providers. Clients will be advised that generally HACC Services do have a charge for service, however, this charge can be negotiated with each provider.

5. RIGHTS AND OBLIGATIONS.

Nothing in the Protocol shall limit any right, obligation or duty of any party to the agreement imposed or granted under the HACC Act or any other legislation.

6. TERMINATION.

Any party may terminate this protocol by 14 days notice in writing. However, there is an agreement that prior to any termination all parties would attempt to resolve any difficulties through a process of negotiation and if necessary by mediation.

7. DEFINITIONS.

7.1 Service Provision Definitions for PERSONAL CARE SERVICES

It is acknowledged that it is difficult to define the different levels of service provision in the delivery of Personal Care services. The following are agreed upon by those involved in this Protocol;

7.1.1 COMPLEX CARE is acknowledged to be;

- Invasive Care
- requiring Bowel Care
- requires Hoist usage
- has Challenging behaviours
- but is not limited to the above.

7.1.2 HIGH LEVEL CARE is acknowledged to;

- have a arrange of environmental factors
- requires a through assessment of the client
- may have 5 hours to a total of 15 hours per week
- personal care with interventions.

7.1.3 MODERATE LEVEL CARE is acknowledged to;

- require between 5 to 10 hours of care per week
- with limited assistance, supervision and prompting
- with limited interventions i.e. requires shaving

7.1.4 LOW LEVEL CARE is acknowledged to be;

- low support needs – supervision, prompting
- WITHOUT need of interventions
- MUST BE Ambulant
- Requiring less than 5 hours per week.

7.2 Assessment

The term 'assessment' is used in HACC to describe processes of varying purpose and intensity. There are 3 levels of Assessment;

Service Specific Assessment

The purpose of this service specific assessment is to determine the:

1. Eligibility for the specific HACC Service
2. The level of service required by the client or carer.
3. The priority of service in comparison to other clients or carers.

Comprehensive Assessment

Comprehensive Assessment describes a path to an outcome and not an event. It is a process by which clients with more complex needs are identified and referred to a Comprehensive Assessment Service i.e. ACAT or Community Options. It involves a holistic look at all the client's needs and not just their need for a specific service. It results in a program of services

designed for their overall needs and monitored by a Case Manager. Its key elements are identification, referral, case planning and case management. Its outcome is appropriate service delivery.

Specialist Assessment

Specialist assessment refers to the involvement of specialists who have expertise in areas not able to be covered by single service assessors or comprehensive assessors. It can be incorporated into a comprehensive assessment process or may be a separate process.

(Reform in HACC Resource Manual, NSW Dept. of Ageing and Disability 1999-2000)

7.3 Case Management

Case management is a holistic process which empowers those involved to explore, develop and implement strategies which can effectively meet client needs.

The main functions of case management are:

- Assessment
- Care planning and resource identification
- Linking the client to services
- Service implementation and co-ordination
- Monitoring of service delivery
- Advocacy
- Review/Evaluation/Closure.

7.4 Care Plan

The care plan should set out details of the services to be provided from all HACC sources. The total fees to be paid by the client and the arrangements for fee payment should also be made clear in the Plan.

7.5 Consumer/Client

A person who receives HACC funded assistance from a HACC Funded service provider. A HACC Client may be an older person, or a person with disability or a carer, or any combination of above.

7.6 Aims

- To provide a comprehensive, co-ordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers.
- To support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to hospital or long term residential care; and

- To provide flexible, timely services that respond to the needs of the consumers.

(National HACC Program Guidelines, 2002)

7.7 Target Group

Clause 4 of the HACC amending Agreement stipulates the program shall be directed towards assisting:

- (a) The target population comprising persons living in the community who, in the absence of basic maintenance and support services provided or to be provided within the scope of the Programs, are at risk of premature or inappropriate long term residential care, including:
 - (1) older and frail person with moderate, severe or profound disabilities;
 - (2) younger persons with moderate, severe or profound disabilities; and
 - (3) such other classes of persons as are agreed upon by the Commonwealth and State Ministers; and
- (b) Carers of persons specified in sub clause(a)

Five special needs groups are identified: people from culturally and linguistically diverse backgrounds; people living in remote and isolated areas; Aboriginal and Torres Strait Islanders; people with dementia; and financially disadvantaged people.

REVIEW OF THE CRITERION OF THIS PROTOCOL WILL BE ON A SIX MONTHLY BASIS.

THE NEXT MEETING FOR THE REVIEW WILL BE HELD AT BAPTIST COMMUNITY SERVICES, HUNTER HUB OFFICE AT ADAMSTOWN ON THE 23RD FEBRUARY, 2006 AT 2PM.