

Department of Health

health

Victorian Home and Community Care program manual 2013



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About this manual

This is the *Victorian Home and Community Care program manual* (the *HACC program manual*).

The manual provides guidelines for HACC organisations about HACC funding, management, reporting and service delivery requirements in Victoria.

Generic administrative requirements are detailed in the service agreement.

Information in the *HACC program manual* replaces the previous February 2003 edition and any subsequent updates. The information has been updated to reflect program adjustments since 2003 and changes to administration and business processes arising from the new HACC Agreement enacted in July 2007.

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.

Each part contains links to other parts of the manual within the text as well as external links to relevant documents. External links are located at the end of each section. These external links include links to downloadable HACC policy documents, such as the HACC assessment framework, the HACC Fees Policy and the HACC Diversity planning and practice policy statement. These documents form part of the program manual and organisations must read them in conjunction with the summary text provided in the manual.

Victorian HACC funded organisations are not required to comply with the *Commonwealth HACC program manual* or the *Commonwealth HACC program guidelines 2012–15*. These resources are only relevant to states and territories where the Commonwealth has sole funding and management responsibilities for the HACC program (see Part 1: National Health Reform Agreement 2011).

Service agreements

Service agreements provide information on the generic administrative requirements for all funded agencies. Service agreements set out the key obligations, objectives, rights and responsibilities of the organisation delivering services and the department providing funding to the organisation. They contain information about:

- terms and conditions
- specific departmental policies that organisations need to comply with under the service agreement
- funding and payment information
- other useful information for organisations delivering services funded by the departments.

HACC funded organisations must comply with the requirements of the *HACC program manual* and the service agreement.

Certain topics contained in the service agreement are included in this manual (for example privacy and police checks) in order to highlight legislative requirements and provide any HACC specific information. Readers should read the relevant sections in the service agreement in conjunction with the *HACC program manual*.

Links to relevant sections of the *Service agreement information kit for funded organisations* are provided.

Links

HACC Review Agreement 2007

<http://www.health.gov.au/internet/main/publishing.nsf/Content/hacc-review.htm>

Service agreement information kit for funded organisations 2011

<http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement/>

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Victorian HACCC program manual

Part 1: Overview and program management



Part 1: Overview and program management

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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 plans, or in a direct quotation.

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

What is the Home and Community Care program?

Introduction

The Home and Community Care (HACC) program is jointly funded by the Commonwealth and Victorian governments under the *Home and Community Care Act (Commonwealth) 1985*. In Victoria, local councils and some other organisations also contribute significant funds and resources to HACC services. Fees paid by people using HACC services also contribute to the resources available.

In accordance with the HACC Review Agreement (2007), services are targeted to older and frail people with moderate, severe or profound disabilities and younger people with moderate, severe or profound disabilities, and their unpaid carers.

HACC services provide basic support and maintenance to people living at home to help avoid premature or inappropriate admission to long-term residential care.

The HACC program aims to:

- provide a coordinated and integrated range of basic maintenance and support services for frail aged people, younger people with disabilities and their carers
- support these people to be more active and independent at home and in the community, thereby enhancing their quality of life and/or preventing inappropriate admission to long-term residential care
- provide flexible, timely and responsive services.

HACC in transition

In May 2013, the state and commonwealth governments agreed to implement the National Disability Insurance Scheme from July 2019. Once fully implemented, the scheme will cover 100,000 Victorians aged 0–64.

As part of this agreement, management of the HACC Program will be split. From July 2015, services for people aged 65 and over will be directly managed by the Commonwealth Government. Services for people aged under 65 will be funded and managed solely by the Victorian Government, until the National Disability Insurance Scheme is in full operation.

In managing the transition, the Commonwealth and Victorian governments have agreed to work together to retain the benefits of Victoria's HACC system.

HACC in transition: Frequently Asked Questions is available on the HACC website.

Who manages the HACC program?

The Commonwealth has primary responsibility for national policy development. The state is responsible for day-to-day management and administration of the HACC program. The two governments jointly agree on operational guidelines and funding levels.

The Victorian Department of Health (the department) is responsible for managing HACC in Victoria. The department is the primary point of contact for service delivery organisations and people using services. It is responsible for program management, service development and agency service agreements.

The department's eight regional offices work in partnership with HACC funded organisations to plan, fund and monitor service provision. The regional offices manage and monitor service agreements between the department and each HACC funded service provider.

Who provides HACC?

In Victoria, approximately 460 organisations deliver HACC services to the community through local councils, hospitals, community health services, nursing services, Aboriginal community controlled organisations, ethno-specific and multicultural organisations and a range of other non-government community organisations.

Local councils play a strong role in the provision of HACC services. This is unique to Victoria. Victorian councils have a long history and commitment to their communities to provide integrated community care services. According to the Municipal Association of Victoria (MAV), Victorian councils contribute over \$100 million annually to 'value-add' to the HACC program.

The local council contribution assists the HACC program to meet both the increasing demand for services and to promote positive ageing strategies within local communities that keep people active and healthier for longer.

Where does HACC fit in the broader service system?

The HACC program is part of a broad service system of community and health services that include:

- community health services
- disability services
- Aged Care Assessment Service (ACAS)
- Commonwealth Home Care Packages
- National Respite for Carers Program
- Commonwealth Government Carelink centres
- Victorian Support for Carers Program.

HACC service providers undertake their planning and service delivery within this broader system. HACC services may be only one of several services a person receives, which is why service coordination is important.

What services are provided?

The HACC program provides basic maintenance and support services that are cost-effective and meet the needs of HACC-eligible people so they can remain in the community.

Services funded by the HACC program include:

- assessment
- access and support
- allied health
- domestic assistance
- delivered meals and centred based meals
- nursing
- personal care
- property maintenance
- planned activity groups
- respite
- activities to build capacity of the service system.

Each of these activities is described in detail in Part 3: 'Services'.

Who uses HACC?

Services funded by the HACC program are provided to people within the target group subject to the person being assessed and their level of need prioritised.

Eligibility for services is not based solely on age, but on the level of difficulty people experience carrying out tasks of daily living.

Activities of daily living include personal care, dressing, preparing meals, house cleaning and maintenance, and using public transport.

Eligibility does not confer entitlement to service provision.

Eligibility means that the person is assessed as being in the HACC program target group and is then prioritised for service provision. Services may not be able to be provided due to other people being assessed as a higher priority or resources not being available.

Organisations should regularly reassess and prioritise existing service users.

Five special needs groups are specified in the HACC Review Agreement (2007) identifying people who may find it more difficult than most to access services. A person's eligibility for HACC services should be determined before considering whether they belong to a special needs group. The five special needs groups are:

- people from Aboriginal and Torres Strait Islander backgrounds
- people from culturally and linguistically diverse (CALD) backgrounds
- people with dementia
- people living in isolated and remote areas
- people experiencing financial disadvantage (including people who are homeless or at risk of homelessness).

For further information about special needs groups see 'Eligibility and priority' and 'Diversity planning', both in Part 2.

HACC services tend to be provided to a high volume of people who each receive a small amount of service. In terms of service duration, some people use HACC services for a short period of time and then no longer require HACC support. Other people may use HACC services over a more extended time and then transition to other support programs.

Where are services provided?

HACC services can be offered to people:

- in their own homes, including retirement villages and independent living units if a resident's contract does not include these services
- in supported residential services, group homes or rooming houses where people in these settings may be eligible to receive HACC services and the service is not part of the rent or the resident's contract
- community venues
- in other arrangements not excluded under the HACC Review Agreement.

For further information see Part 2: 'Eligibility and access'.

Links

HACC Review Agreement 2007

<http://www.health.gov.au/internet/main/publishing.nsf/Content/hacc-review.htm>

HACC in Transition

<http://www.health.vic.gov.au/hacc>

Municipal Association of Victoria

<http://www.mav.asn.au/Pages/default.aspx>

National Health Reform Agreement 2011

http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf

For a list of HACC service providers see:

http://www.health.vic.gov.au/hacc/downloads/pdf/list_hacc_agencies2010.pdf

For further information and facts about the use of HACC services, see:

http://www.health.vic.gov.au/hacc/hacc_victoria/facts.htm.

Legislative requirements

HACC Act and Review agreement

The Commonwealth and Victorian governments jointly fund the HACC program under the *Home and Community Care Act (Commonwealth) 1985*.

Both governments provide funds for the program. Under matching arrangements, the Commonwealth contributes about 60 per cent and the Victorian Government about 40 per cent. The Victorian Government has generally contributed additional unmatched funds.

The formal basis for the HACC program is a bilateral agreement between the Commonwealth and Victorian governments. The HACC Review Agreement between the Commonwealth and Victoria was implemented on 1 July 2007. A guide to the agreement is available on the Commonwealth Government's health website.

Under the agreement, the Victorian Government agreed to adhere to the:

- National Framework of Principles for Delivering Services to Indigenous Australians (2004)
- Charter of Public Service in a Culturally Diverse Society (Commonwealth Government 1998).

HACC due recognition

The HACC Review Agreement requires HACC funded organisations to formally acknowledge the Commonwealth and Victorian governments' contribution to the HACC program. This is to ensure that the Australian community is informed about how public money is being spent.

The Victorian Government entered into a licence agreement with the Commonwealth, designed to prevent unauthorised use of the HACC logo. In turn, the Victorian Government sublicenses HACC funded organisations.

Victoria's logo licence agreement with the Commonwealth Government and sublicense agreement with funded organisations ended on 30 June 2012. Negotiations for a new agreement are underway. Until new arrangements are in place **the existing arrangement will continue.**

Failure to acknowledge the source of funds may result in a fine for the Victorian HACC program.

As of March 2013 the Victorian Government introduced its own due recognition requirements and all funded organisations have been advised of these requirements.

For HACC funded organisations it is 'business as usual' and the existing HACC due recognition requirements as defined below remain unaltered.

This means that no other form of due recognition is required other than the HACC logo or form of words when specifically referencing HACC funded programs.

Meeting HACC due recognition requirements

Organisations can meet the due recognition requirements by using the HACC logo or the appropriate form of words identified below.

Logo

The HACC logo has been created to provide a simple way to acknowledge HACC program funding. To use the HACC logo the agency must have signed a copy of the sublicense. The sublicense is available from the department.

Form of words

If your organisation decides not to sign the deed of sublicence, the due recognition requirement for the HACCC program can be met by using a simple phrase. The following examples illustrate some alternative phrases that are considered appropriate.

This activity/project/service/organisation:

- was jointly funded by the Commonwealth and Victorian governments
- is supported by financial assistance from the Commonwealth and Victorian governments.

In using the HACCC logo the following guidelines must be adhered to:

- the logo cannot be altered in any way, except for size
- the text underneath the logo can be made larger and more legible but cannot be removed
- the logo may be used in mono (black) or coloured (authorised PMS colours are burgundy PMS690CVC and gold PMS126CVC, the logo cannot be reproduced in any other colours).

Exclusions

Clause 4(2) of the HACCC Review Agreement details a number of services that are outside the scope of the HACCC program, because funding is provided through other government programs. These exclusions do not relate to a person's eligibility to receive services. See Part 2 for information on eligibility.

The HACCC program cannot fund the services listed below:

- the provision of accommodation (including rehousing and supported accommodation) or a related support service
- the provision of a health aid or appliance, except where these items are not normally available through other government funded programs, are required for the operation of an approved project, and remain the property of the service provider
- the provision of treatment services for acute illness (including a convalescent or post-acute care service), except in circumstances where a service provides overall maintenance and support to people assessed as being within the target population, who are recovering from a previous period of acute care treatment
- rehabilitative services directed solely towards increasing a person's level of independent functioning
- services provided for people with a specific disability other than those with dementia or a related condition
- services provided primarily for parents and children assessed as being within the category of families in crisis
- specialist palliative care services.

Role of Victorian Department of Health

The Victorian Department of Health is responsible for managing HACC in Victoria in accordance with the national policy and objectives and is the primary point of contact for agencies and service users.

The department has eight regional offices and a central office in Melbourne. The department conducts most of its business with service providers and service users via its regional offices. Each regional office has a service planning and performance management responsibility for the particular region. Each regional office also has a contact for information and advice regarding HACC.

Regional offices are responsible for:

- working with central office on policy and program development and understanding the impact of policies and priorities on the regional service system
- working in partnership with providers and service users to identify regional priorities
- negotiating service agreements to ensure the regional service system is equitable and accessible
- working with HACC funded organisations on a range of quality assurance and improvement initiatives such as equitable access for special needs groups including strategies to support those who experience barriers to access as a result of their diversity
- managing complaints in relation to the HACC program.

Role of HACC funded organisations

HACC funded organisations are responsible for managing and operating their services so as to comply with HACC policies, quality standards, guidelines and other requirements. This includes:

- providing services in accordance with the Community Care Common Standards guide, statement of rights and responsibilities and Victorian HACC Program Complaints Policy
- delivering services according to the relevant HACC policies, guidelines and other requirements included in the manual
- delivering the agreed outputs and meeting performance requirements and conditions as specified in the Victorian Department of Health service agreement including minimum data set (MDS) reporting and financial requirements
- implementing policy and practice in relation to service coordination, active service model approaches and diversity planning and practices
- recruiting, supporting and supervising staff, and identifying and meeting the training needs of staff and volunteers
- meeting duty of care requirements.

When requested by the Commonwealth Department of Social Services or the Victorian Department of Health, HACC funded organisations must allow free and reasonable access to, and provide assistance with the inspection of HACC-related administrative records, accounts, land, equipment, transport items and buildings.

This access may be used to ensure that funded organisations are complying with the conditions specified in this manual and the service agreement with the Victorian Department of Health.

Other legislation

Other legislation relevant to the planning and delivery of HACC services is noted in each section of this manual.

Links

HACC Review Agreement (2007)

<http://www.health.gov.au/internet/main/publishing.nsf/Content/hacc-review.htm>

Service agreement information kit for funded organisations (2011)

<http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement/>

National framework of principles for government service delivery delivering services to Indigenous Australians (2004)

<http://www.atns.net.au/agreement.asp?EntityID=2559>

Information about the HACC logo sublicence can be obtained by emailing hacc@health.vic.gov.au

For information and facts about the use of HACC services, see

http://www.health.vic.gov.au/hacc/hacc_victoria/facts.htm.

Victorian policy and program directions

Victorian health priorities

The Victorian Health Priorities Framework 2012–2022 identifies seven priority areas to build a more effective service system for all Victorians:

- developing a system that is responsive to people's needs
- improving every Victorian's health status and health experience
- expanding service, workforce and system capacity
- increasing the system's financial sustainability and productivity
- implementing continuous improvements and innovation
- increasing accountability and transparency
- utilising e-health and communication technology.

Current Victorian HACC program directions are described in the *Victorian HACC triennial plan 2012–15*. This plan describes how the HACC program will contribute to realising the Victorian health priority areas through:

- an ongoing focus on equity of resource allocation
- ongoing implementation of the active service model
- responding to people with diverse needs
- improved assessment and care planning.

The *HACC triennial plan* and priorities for 2012–15 have been developed in light of the Victorian Health Plans, to ensure that investments in Victorian HACC services contribute to the broader achievement of a more effective health and community care service system into the future.

In developing priorities for 2012–15, their alignment with strategic planning in other program areas such as disability services, chronic disease management and mental health has also been considered. Such an approach helps facilitate continued linkages between these and HACC services to better manage people's chronic conditions in the community, and ensure people are able to access the services that meet their needs.

The unique service profile of Home and Community Care in Victoria ensures that HACC services work closely with the primary care system and Aged Care Assessment Service (ACAS) to reduce demand on other health services, better manage chronic disease conditions of people in the community and ensure that older people get the right care and support.

Program directions

HACC services are provided in the context of current program directions. These include the active service model, diversity planning and practice and strengthened assessment and care planning.

These initiatives, together with broader Victorian initiatives described below, emphasise early intervention and prevention to assist people to

- participate in everyday activities
- maintain or rebuild confidence
- improve social connectedness and emotional wellbeing
- stay active and healthy.

HACC service providers should be actively implementing these approaches to HACC service delivery.

Active service model

The active service model is a quality improvement initiative which explicitly focuses on promoting capacity building and restorative care in relation to physical function and social and psychological wellbeing. The active service model applies to all people accessing HACC services and to all HACC service types. While the service response will differ according to each person's needs and goals, it is underpinned by the core components of the model which are:

- capacity building, restorative care and social inclusion to maintain or promote a person's capacity to live as independently and autonomously as possible
- a holistic person-centred approach to care, promoting wellness and active participation in goal setting and decisions about care
- timely and flexible services that respond to a person's goals and their carer's needs and circumstances in order to maximise a person's independence and support the care relationship
- collaborative relationships between providers, for the benefit of people using services.

All HACC service providers deliver services within this context. For further information about active service model see the 'Active service model' section in Part 3.

Diversity planning and practice

Diversity planning and practice aims to contribute to an equitable, accessible, person-centred, responsive and high-quality HACC service system while ensuring alignment with Victorian health priorities. The focus of diversity planning is on the five HACC special needs groups as well as consideration of characteristics such as age, gender-identity, sexual orientation and socio-economic status of all groups. For further information about diversity planning and practice see the 'Diversity' section in Part 2.

Strengthening assessment and care planning

The *Framework for assessment in the HACC program in Victoria* (Department of Human Services 2007) describes the HACC program policy for assessment, including the requirements for a Living at home assessment. For further information about assessment and care planning see:

- 'Service coordination, assessment and care planning' in Part 2
- 'Living at home assessment' in Part 3.

Victorian Government initiatives

Integrated chronic disease management, supporting care relationships and service coordination are key initiatives that underpin HACC program directions and a person-centred approach to care.

Integrated chronic disease management

HACC plays an important role in supporting frail older people with chronic and complex conditions, younger people with a disability, and their carers. Integrated chronic disease management refers to the provision of person-centred care by services working together with the person to ensure coordination, consistency and continuity of care over time and through different stages of their condition. Where people with chronic conditions are receiving HACC services, they should be provided in a manner that is well planned, integrated, and supports the person's capacity to self-manage.

Care relationships

The *Carers Recognition Act 2012* came into effect on 1 July 2012. Section 7 of the Act sets out the principle that a carer should be respected and recognised:

- as an individual with his or her own needs
- as a carer
- as someone with special knowledge of the person in his or her care.

The following information is taken from section 4.23 of the *Service agreement information kit for funded organisations*:

The purpose of the Act is to recognise, promote and value the role of people in care relationships. It formally acknowledges the important contribution that people in care relationships make to our community and the unique knowledge that carers hold of the person in their care.

For the purposes of the Act, a care relationship exists where the person being cared for is an older person, or a person with a disability, a mental illness or an ongoing medical condition. The Act also includes situations where someone is being cared for under the *Children, Youth and Families Act 2005*, in a foster, kinship or permanent care arrangement.

State government departments, local councils and service organisations and their subcontractors funded by government to provide programs or services to people in care relationships (care support organisations) are required to take all practical measures to comply with the care relationship principles in the Act and to reflect them when developing and implementing support for people in care relationships.

The Act also specifies that care support organisations must prepare a report on its compliance with its obligations under the Act, to be included in the care support organisation's annual report. This may be as simple as a paragraph describing activity undertaken over the year to comply with the Act.

Service coordination

Service coordination supports HACC service providers to coordinate and integrate their service delivery with the broader health and community services system. HACC service may be one of several services a person receives so a partnership approach with other service providers is used to ensure a coordinated and integrated approach to support.

All HACC funded organisations are required to work within the service coordination policy described in the *Better access to services framework* (Department of Human Services 2001). The *Victorian service coordination practice manual* outlines the practices, processes and protocols to support service coordination and the use of the Service Coordination Tool Templates (SCTT). For further information, see 'Service coordination, assessment and care planning' in Part 2.

Emergency management

The Vulnerable People in Emergencies Policy 2012 has been developed to improve the safety of vulnerable people in emergencies, by supporting emergency planning with and for vulnerable people.

The policy uses the existing relationships of funded organisations with vulnerable people to support personal emergency planning and improve their safety and resilience.

For details see:

- section 4.18, 'Vulnerable People in Emergencies Policy' in the *Service agreement information kit*
- HACC fact sheet — *HACC funding to support vulnerable people in emergencies* (Department of Health 2013).

The department works with the health sector to prepare for, respond to and recover from emergencies that impact or affect health sector organisations and the health of Victorians.

The department has developed the Emergency Preparedness Clients and Services Policy: Summer 2012–13 to assist the health sector to prepare for external hazards that may occur during the period of heightened risk associated with summer, thereby better protecting and enhancing the health and safety of clients.

A suite of communication resources has been developed to encourage and educate individuals and the community to be aware of the impact of extreme heat on human health.

For details see section 4.19, 'Emergency Preparedness Clients and Services Policy' in the *Service agreement information kit*.

Other

Other key Victorian directions include, but are not limited to:

- the Victorian Charter of Human Rights and Responsibilities 2008, which describes the Victorian Government's commitment that all Victorians are treated with equality, fairness and respect
- the *Victorian state disability plan 2002–12*, which outlines the policy directions for disability services in Victoria based on the principles of equality, dignity and self-determination, diversity and non-discrimination

- *Because mental health matters: Victorian mental health reform strategy 2009–19*, which outlines the Victorian Government's agenda for change and improvement in the way mental health is addressed, based around the four key elements of prevention, early intervention, recovery and social inclusion.

These policy directions share the common intent of early intervention, linking people to community based interventions and supports, self-determination, goal directed care planning, improving emotional wellbeing, social connectedness and respect for diversity.

Links

Because mental health matters: Victorian mental health reform strategy 2009–19

(Department of Health 2012)

http://www.health.vic.gov.au/mentalhealth/reform/documents/mhs_web_summary.pdf

Better Access to services framework (Department of Human Services 2001)

http://www.health.vic.gov.au/pcps/downloads/publications/BATS_Policy&op-fmwkrk_July01.pdf

Carers Recognition Act (Victoria) 2012

www.dhs.vic.gov.au/carersact

Carer Recognition Act (Commonwealth) 2010

http://www.fahcsia.gov.au/sites/default/files/documents/07_2012/carers_recognition_act_0.pdf

Service agreement information kit for funded organisations 2011

<http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement/>

Resource for providers of HACC and primary health services: how the ASM and ICDM policies align

(Department of Health) http://www.health.vic.gov.au/pch/downloads/hacc_icdm_alignment.pdf

Service coordination resources

<http://www.health.vic.gov.au/pcps/coordination/overview.htm>

Victorian Health Priorities Framework 2012–22: Metropolitan Health Plan

<http://docs.health.vic.gov.au/docs/doc/Victorian-Health-Priorities-Framework-2012-2022:-Metropolitan-Health-Plan>

Victorian Health Plan

<http://www.health.vic.gov.au/healthplan2022/>

Vulnerable People in Emergencies Policy 2012

<http://www.dhs.vic.gov.au/funded-agency-channel/spotlight/vulnerable-people-in-emergencies-policy>

Further service coordination resources:

<http://www.health.vic.gov.au/pcps/coordination/overview.htm>

<http://www.health.vic.gov.au/pcps/workforce/index.htm>

HACC quality framework

Introduction

Quality assurance is applicable to the management and delivery of all HACC services.

This section outlines the Victorian HACC quality framework which aims to ensure HACC services are of high quality and people's rights are upheld.

This framework comprises the:

- *Community Care Common Standards guide*
- *HACC statement of rights and responsibilities*
- *Victorian HACC Program Complaints Policy.*

Community Care Common Standards guide

On 1 March 2011 the Community Care Common Standards (CCCS) replaced the HACC National Service Standards across Australia. The CCCS are part of an ongoing process of reform to develop and streamline arrangements in community care by the Australian Government and state and territory governments that has been underway since 2005.

The CCCS are applicable to the HACC program, Commonwealth Home Care Packages and National Respite for Carers Program. The three CCCS Standards are:

- Standard 1 Effective Management
- Standard 2 Appropriate Access and Service Delivery
- Standard 3 Service User Rights and Responsibilities.

There are 18 expected outcomes: eight effective management outcomes; five appropriate access and service delivery outcomes; and five service user rights and responsibilities outcomes.

The CCCS guide contains information about the standards and expected outcomes, the quality review tools and process and related documents.

While the CCCS are similar in content to the HACC National Service Standards there are some key differences from the previous two national standards assessment rounds.

- In most cases only one HACC service type at each HACC funded organisation was assessed. Under CCCS all HACC funded client services at a HACC funded organisation will be subjected to the quality review.
- There is no scoring system. Outcomes are rated as 'met' or 'not met'.
- Funded organisations will be required to complete a self-assessment prior to the site visit. This was not a requirement under the HACC National Service Standards Instrument.
- The improvement plan resulting from the CCCS quality review will be updated annually and submitted to the department by those HACC funded organisations that have not met all 18 expected outcomes.

Victorian HACC quality review resource

Organisations funded to provide HACC services in Victoria are required to follow a variety of Victorian policy and program requirements. These include:

- *HACC program manual*
- Diversity planning and practice
- active service model implementation
- service coordination
- *Framework for assessment in the HACC program.*

There are also State Government of Victoria requirements such as the Working with Children Check and card.

Victorian requirements have been incorporated into the quality review process for HACC funded organisations via the *Victorian Home and Community Care (HACC) quality review resource*.

Three year quality review cycle

Every three years, each HACC funded organisation will have a quality review against the Community Care Common Standards. The quality review process for the current cycle July 2011 to June 2014 is detailed below.

Quality reviews for Commonwealth funded programs will be conducted by quality reviewers from the Department of Social Services (DSS).

Australian Healthcare Associates (AHA) has been appointed by the Department of Health to conduct, on the department's behalf, the CCCS quality reviews of HACC funded organisations in Victoria other than those that have accreditation with the Australian Council on Healthcare Standards (ACHS) or Quality Improvement and Community Services Accreditation Inc (QICSA), now known as Quality Innovation Performance (QIP).

For HACC funded organisations with whole-of-organisation ACHS or QIP accreditation as at 28 February 2012, the CCCS quality review for HACC funding will occur with their accreditation review. In some cases this means the quality review will be conducted later than 30 June 2014. Funded organisations should contact ACHS or QIP regarding their accreditation review schedules and for information about the review process.

If a HACC funded organisation ceases to have whole-of-organisation ACHS or QIP accreditation between 28 February 2012 and 31 March 2014, the quality review will be conducted by AHA.

Where possible funded organisations with both Commonwealth community aged care funding and HACC funding will have a joint quality review conducted by reviewers from both AHA and DSS.

However if an organisation has both types of funding and ACHS or QIP accreditation as at 28 February 2012, there will be a separate quality review for Commonwealth community aged care funding by DSS quality reviewers.

The HACC program presentation given at the 2012 CCCS information sessions is available below. This presentation gives an overview of the policy context for the CCCS quality reviews in Victoria.

Improvement plan annual submission

Each HACC funded organisation that has not met all 18 expected outcomes is required to update their improvement plan (developed during the quality review) and submit it annually on the anniversary of the quality review. For example if the quality review is conducted in June 2013 then the first updated improvement plan will be submitted in June 2014 and the second update improvement plan will be submitted in June 2015. The updated improvement plan will document progress to date of implementation of required improvements and/or improvement opportunities.

HACC statement of rights and responsibilities

Older and frail people with moderate, severe or profound disabilities and younger people with moderate, severe or profound disabilities and their unpaid carers comprise the HACC target group.

In the rights and responsibilities statement below, any reference to 'the people' is intended to apply equally to all members of the target group. In some instances, it has been necessary to make a distinction between the groups to emphasise their particular needs or to make the intention of the statement clear.

The HACC program statement of rights and responsibilities recognises that:

- the program assists people who are at risk of premature or inappropriate long-term residential care and their carers
- the program aims to enhance the quality of life and independence of those at risk people and their carers
- the program is administered within available resources and in accordance with the principles and goals set out in the HACC agreements
- people who use HACC funded services retain their status as members of Australian society and enjoy the rights and responsibilities consistent with this status
- funded organisations providing HACC services operate under the constraints of relevant law.

Rationale for rights and responsibilities statement

The HACC statement of rights and responsibilities aims to ensure that both people receiving services, and the funded organisations providing these services, are aware of their rights and responsibilities and can be confident in exercising them.

The need to promote respect for the rights of people receiving HACC services arises from the nature of their relationship with funded organisations providing services.

People using HACC services rely significantly on these services to maintain their ability to live in the community. The nature of this relationship imposes obligations on funded organisations and requires services to be responsive to the changing needs of each person.

Funded organisations must involve each person when determining the support to be provided. This is crucial to the creation of an environment in which people can be confident in exercising their rights and responsibilities.

HACC funded organisations should distribute a copy of the statement of rights and responsibilities and advocacy information to all people receiving services, carers and families. Strategies should be developed to ensure that specific groups – for example people from culturally and linguistically diverse backgrounds and people with disabilities – understand and are able to participate in these processes.

Rights and responsibilities statement

Service recipients' rights

HACC service recipients' key rights within the HACC program are:

- the right to respect for individual human worth and dignity
- the right to be treated with courtesy
- the right to be assessed for access to services without discrimination
- the right to be informed and consulted about available services and other relevant matters
- the right to be part of decisions made about their care
- the right to choose from available alternatives
- the right to pursue any complaint about service provision without retribution
- the right to involve an advocate of their choice
- the right to receive high-quality services
- the right to privacy and confidentiality, and access to all personal information kept about themselves.

Service recipient responsibilities

Consistent with their status as members of Australian society, people receiving HACC services have a responsibility:

- to respect the human worth and dignity of the service provider staff and other people using the service
- to treat service provider staff and other people using the service with courtesy
- for the results of any decisions they make
- to play their part in helping the funded organisation to provide them with services
- to provide a safe work environment for staff and help them to provide people with services safely.

Funded organisations' responsibilities

In providing services, funded organisations have a responsibility:

- to enhance and respect the independence and dignity of the service recipient
- to ensure that the service recipient's access to a service is decided only on the basis of need and the capacity of the service to meet that need
- to inform service recipients about options for HACC program support
- to inform service recipients of their rights and responsibilities in relation to HACC services
- to involve the service recipients and carer in decisions on the assessment and service delivery plan

- to negotiate with the service recipients before a change is made to the service being provided
- to be responsive to the diverse social, cultural and physical experiences and needs of service recipients
- to recognise the role of carers and be responsive to their need for support
- to inform the service recipient about the service to be delivered and any fees charged
- to inform the service recipient of the standards to expect in relation to services they may receive
- to ensure that the service recipient continues to receive services agreed with the provider, taking the service recipient's changing needs into account
- to respect the privacy and confidentiality of the service recipient
- to allow the service recipient access to information held by the funded organisation
- to allow the carer access to information held by the provider about the service recipient where the carer is the legal guardian or has been so authorised by the service recipient
- to deliver services to the service recipient in a safe manner
- to respect a service recipient's refusal of a service and to ensure any future attempt by the service recipient to access a HACC service is not prejudiced because of that refusal
- to deal with service recipient's complaints fairly and promptly and without retribution
- to mediate and attempt to negotiate a solution if conflict arises between the carer and the older person or younger person with a disability
- to accept the service recipient's choice and involvement of an advocate to represent his or her interests
- to take into account the service recipient views when planning, managing and evaluating service provision.

This rights and responsibilities statement provides the framework for a complaints policy and procedures in the HACC program, and is based on both funded organisations and administering government departments having policies and procedures in place to inform service recipients of their right to complain, and to resolve any complaints received. Funded organisations should ensure that their own specific policies and procedures for handling complaints are consistent with the framework outlined in this policy.

Victorian HACC Program Complaints Policy

Overview

The Community Care Common Standards (CCCS) guide and this policy provide the framework for a complaints policy and procedures in the HACC program and are based on both service provider organisations and administering government departments having policies and procedures in place to inform people of their right to complain, and to resolve any complaints received.

Complaints policy

The right of people to lodge a complaint about a service is a fundamental component of the overall strategy to promote the rights of people using services in the HACC program, as set out in the program's statement of rights and responsibilities.

This policy provides the framework for a complaints policy and procedures in the HACC program and is based on the proviso that both service provider organisations and administering government departments have policies in place to inform people of their right to complain, and procedures to resolve any complaints received. Funded organisations should ensure that their own specific policies and procedures for handling complaints are consistent with the framework outlined in this policy and the CCCS guide.

More detailed information regarding the development of organisation specific complaints policy and procedures is provided in the CCCS guide.

The standards clearly outline the principles to guide funded organisations in the establishment of fair, effective and accessible complaints procedures. Funded organisations should refer to the standards when establishing service specific complaint procedures.

Right to complain

People receiving government funded services are entitled to have complaints investigated objectively and without fear of retribution. In the HACC context, such a right of complaint is established in the statement of rights and responsibilities, which states the right of people to 'pursue any complaint about service provision without retribution'. The statement also establishes the responsibility of funded organisations to 'deal with a service user's complaints fairly and promptly and without retribution'.

Complaint mechanisms

Where appropriate, complaints should be dealt with in the first instance by the organisation providing the service. The CCCS guide requires all funded organisations to implement a policy for dealing with and monitoring complaints.

Such internal complaint mechanisms should include a written policy describing how a complaint will be handled. Information on this policy should be made available and explained to all people receiving government funded services. In situations where a complaint is upheld, funded organisations should review their access and/or service delivery practices, with a view to making improvements in the service.

Resolving complaints or concerns

People have the right to lodge a complaint about a service. It is required that all HACC funded organisations develop and distribute an impartial policy statement and a set of procedures for resolving complaints.

An effective policy should provide the means for funded organisations to:

- learn from their experience of complaints management
- review the way they do business
- respond to evolving service user requirements and changes in management environments.

Funded organisations should ensure all policies and procedures for handling complaints are consistent with:

- the Community Care Common Standards guide
- HACC statement of rights and responsibilities.

Under the CCCS, HACC funded organisations are required to provide information about the funded organisation's complaints and feedback processes to all people receiving services, as well as their carers and families. Strategies should be developed to ensure that specific groups — for example people from culturally and linguistically diverse backgrounds and people with disabilities — understand and are able to participate in these processes.

It is likely that some complaints will need to be addressed in a forum that is not associated with, or dependent on, the particular service concerned. This may occur when it is not possible to resolve the complaint at the organisational level or when the person making the complaint does not wish to approach the organisation.

People who remain dissatisfied or who do not wish to raise the complaint with the funded organisation should have recourse to assistance from state or territory departments or other complaint mechanisms independent of the organisation.

State/territory departments

It is appropriate for the state department managing HACC to play a formal role in complaints that cannot be resolved at the organisational level, or are raised by people who feel that they are unable to approach the organisation directly.

In Victoria people can contact their nearest departmental regional office via the department's website, or by referring to the *White pages telephone directory*.

Legal procedures

This statement is subsidiary to all existing common and statutory legal procedures in Victoria.

Use of advocates in the complaint process

Advocacy can play a critical role assisting people to pursue and resolve complaints. The HACC statement of rights and responsibilities makes it clear that people receiving services have the right to involve an advocate of their choice in their dealings with both funded organisations providing services and administering government departments.

However, the role of the advocate is not to mediate between the person making the complaint and the funded organisation or to arbitrate in a dispute, but rather to speak and act on behalf of the person making the complaint. When a complaint cannot be resolved at the funded organisation level, the role of mediation and arbitration lies with the Victorian Department of Health.

Other resources and organisations

Resources and other organisations which may assist funded organisations and complainants in resolving complaints are listed below. Please consult the *White pages telephone directory* or directory assistance for up to date phone numbers.

Health Services Commission

The Health Services Commission deals with complaints concerning any private or public health service provider, including doctors, nurses, allied health professionals and naturopaths. The aim of the commission is to mediate and conciliate between parties.

Disability Services Commissioner

The Disability Services Commissioner (DSC) is an independent statutory authority of the Victorian State Government established under the *Disability Act 2006* to provide an independent and accessible resolution process for people with a disability who have a complaint about services provided by the Department of Human Services, registered disability service providers and funded or contracted services provided under the Disability Act.

The DSC does not deal with complaints that relate to services funded under the HACCC program. Under the terms of a protocol agreed to between the DSC and the Department of Health, the DSC will refer any issue, complaint or enquiry regarding a HACCC service that comes to the attention of the DSC to the appropriate department HACCC regional contact.

State government Ombudsman

The Ombudsman for the state government deals with complaints concerning actions of government departments. The Ombudsman's office also has jurisdiction over the administrative actions of local government officers. However, the Ombudsman cannot act if the complaint concerns a decision or action of an elected council or councillor.

Victorian Equal Opportunity and Human Rights Commission

The Equal Opportunity Commission will deal with complaints concerning discrimination on the grounds of disability, sex, race, age, industrial activity, marital, parental or carer status, political or religious beliefs, sexual orientation or pregnancy.

The commission will assist people to prepare statements and to lodge a complaint. The role of the commission is to then mediate between parties to reach resolution of the complaint.

Office of the Public Advocate

The Office of the Public Advocate represents the interests of Victorian people with a disability. The office is a statutory agency, independent of government and has the power to investigate and take action in situations where people are exploited, neglected or abused. Individual advocacy can also be provided for people with a disability who are being abused or neglected, and where no other advocacy is available. Independent guardians can be provided for people with a disability when the Guardianship and Administration Board make orders.

Regulatory industry boards

These are organisations that regulate the conduct of particular professions. They also deal with complaints against professionals. Most state-based medical regulatory organisations now come under the auspice of the Australian Health Practitioner Regulation Agency (AHPRA).

Links

Australian Healthcare Associates (AHA)

<http://www.ahaconsulting.com.au/Project-Resources/Victorian--HACC-CCCS-Quality-Reviews.aspx>

Community Care Common Standards (CCCS) guide (Commonwealth Department of Health and Ageing, 2010) <http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-publicat-commcare-standards.htm>

Department of Health (Victoria)

<http://www.health.vic.gov.au/>

Department of Social Services (DSS)

<http://www.health.gov.au/>

Disability Services Commissioner (DSC)

<http://www.odsc.vic.gov.au/>

HACC Review Agreement 2007

<http://www.health.gov.au/internet/main/publishing.nsf/Content/hacc-review.htm>

Service agreement information kit for funded organisations 2011

<http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement/>

Office of the Public Advocate

<http://www.publicadvocate.vic.gov.au/>

Victorian Equal Opportunity and Human Rights Commission

<http://www.humanrightscommission.vic.gov.au/>

Victorian HACC Quality Review Resource (Department of Health 2012)

http://www.health.vic.gov.au/hacc/downloads/pdf/quality_resource2012.pdf

Victorian Ombudsman

<http://www.ombudsman.vic.gov.au/www/html/7-home-page.asp>

White Pages Telephone Directory

<http://www.whitepages.com.au/wp/busSearch.jhtml>

2012 CCCS information session presentation

http://www.health.vic.gov.au/hacc/downloads/pdf/cccs_presentation.pdf

Employee and related requirements

Staff education and training

Education and training is integral to ensuring that client and carer needs are met through the provision of appropriate, well-managed services, delivered by staff with relevant skills and knowledge. Both paid staff and volunteers at all levels should be encouraged and supported to expand their skills and knowledge. The effectiveness of education and training in ensuring quality services is dependent on staff members being supported in learning and practicing new skills and knowledge.

In accordance with the Community Care Common Standards funded organisations are responsible for staff members having the relevant qualifications, skills and knowledge required to undertake the activities that they are allocated to do and have access to registered vocational training and appropriate, quality inservice training.

To enable appropriate training to be identified HACC organisations should undertake education and training needs analysis and develop and implement training plans. All staff members and volunteers are expected to have current skills and knowledge relevant to their role.

Funded organisations that use volunteers exclusively (except for the paid volunteer coordinator) or a mix of volunteers and paid staff are expected to provide recruitment, training and supervision appropriate to the volunteer role. In order to achieve this, volunteers should be offered ongoing training and information as well as appropriate levels of supervision and support. Volunteers are not expected to undertake registered vocational training.

HACC staff members should take the responsibility for ongoing development of the skills and knowledge necessary to fulfil their roles and responsibilities. The HACC program benefits from a diverse workforce with people from many culturally and linguistically diverse backgrounds. Basic English literacy and numeracy skills are required so that staff members can properly understand policies, procedures and work instructions.

Victorian HACC Education and Training Service

The statewide Victorian HACC Education and Training Service provides education and training at no cost for staff delivering services provided by the HACC program, and staff of organisations who are subcontracted to provide HACC services. HACC volunteers are also eligible to attend training and education relevant to their roles.

HACC-funded training is intended to provide training which is of specific relevance to the HACC program. It is not intended to meet all education and training needs of the HACC workforce. This remains the responsibility of:

- HACC funded organisations to ensure that employees and volunteers have the necessary qualifications and training for the roles and tasks they undertake.
- The VET system to fund vocational education and training that leads to qualifications and the attainment of units of competency.
- The Higher Education system to fund and deliver higher education.

The Service offers a range of education and training opportunities including inservice training, registered vocational education and training, and competency based training. Training is delivered across the state utilising a variety of methods including online, face-to-face and a combination of both.

Education and training provided is developed in consultation with funded organisations to reflect the diverse needs of the HACC workforce and to support current initiatives and reforms of the HACC program. A calendar is developed each six months.

From 1 July 2013 the Victorian HACC Education and Training Service is delivered by Chisholm Institute of TAFE. As a Registered Training Organisation all trainers hold training and assessment competencies as determined by the National Quality Council. The Service has a dedicated website for training course selection and online enrolment.

Qualifications and registration

Managers, coordinators and supervisors

Staff employed to undertake management, coordination and supervision roles are expected to have skills, knowledge and qualifications appropriate to the work undertaken. There are qualifications and training to assist people to fulfil the requirements and responsibilities of these roles both at a higher education and vocational education and training level. For example, the CHC08 Community Services Training Package includes qualifications targeted to managers, supervisors or coordinators. These may be more suited to people already in the workforce.

HACC assessors

Staff employed to undertake Living at home assessments are expected to have relevant skills and qualifications. The HACC assessment framework requires that 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 and in some cases, the registered occupation is listed. Examples include:

- registered nurse (formerly known as a 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.

Nursing

Staff providing HACC nursing must have the appropriate qualification for a registered nurse (formerly known as division 1 nurse) or enrolled nurse (formerly known as division 2 nurse). Nurses must be registered with the Nursing and Midwifery Board of Australia which is part of the Australian Health Practitioner Regulation Agency.

The enrolled nurse is an associate to the registered nurse who demonstrates competence in the provision of person-centred care as specified by the registering authority's licence to practise, educational preparation and context of care.

Allied health

Professional staff providing HACC allied health are expected to have the appropriate qualification/registration/professional requirement as outlined in this manual. The funded occupations are: occupational therapist, podiatrist, physiotherapist, psychologist, social worker, dietitian and speech pathologist.

Health professionals must comply with the registration requirements as specified by the Australian Health Practitioner Regulation Agency unless otherwise stated as follows.

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

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).

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

The type of professional service should be specified in the organisation's service agreement with the Victorian Department of Health.

As noted on the Australian Health Practitioner Registration Agency website, allied health assistants operate within the scope of their defined roles and responsibilities and under the supervision of an allied health professional.

Allied health assistants work under the direction of most allied health professions, that is, dietetics, occupational therapy, physiotherapy, podiatry, occupational therapy and speech pathology.

All allied health assistants employed with HACC allied health funding must hold either of the following qualifications:

HLT07 Health Training Package Version 4

- HLT42507 Certificate IV in Allied Health Assistance

or

HLT07 Health Training Package Version 5

- HLT42512 Certificate IV in Allied Health Assistance

They must also hold the specialisation competency unit electives for the allied health profession assisted. For example the specialisation electives for physiotherapy must be held for assistance to be given to a physiotherapist.

The allied health assistant must be provided with adequate guidance, supervision and instructions by a designated allied health professional with the relevant allied health qualification, for example a podiatrist must supervise a podiatry allied health assistant.

See *Supervision and delegation framework for allied health assistants* (Department of Health 2012).

Community care workers

The department participates in the development and review of national competency-based training that forms the Community Services Training Package. This is the framework for registered training for community care workers.

The appropriate Certificate III level qualification is the minimum standard of qualification required in Victoria for HACC program funded community care workers.

Over time the structure of the vocational education and training system has changed therefore the names and content of qualifications have changed. The qualifications recognised by the HACC program in Victoria for HACC community care workers are listed below. If a community care worker holds any of these qualifications they are not expected to complete another qualification. However if the qualification held is more than ten years old the community care worker could benefit from completing a more recently developed qualification or from gap training by doing individual competency units as required.

If a community care worker holds a qualification not listed below, gap training may also provide the necessary skills for the delivery of HACC services but this would depend on how well the qualification is related to the HACC target group and the nature of HACC service provision.

See also gap training information below.

Vocational training prior to 1994

Registered vocational (non-professional) qualifications obtained prior to 1994 are not recognised by the HACC program in Victoria.

Vocational training between 1994 and 2000

Between 1994 and 31 December 2000 community care workers providing HACC program funded services usually undertook the Certificate III or IV in Community Services (Home and Community Care) which were Victorian registered qualifications. Since 1 January 2001 these qualifications have no longer been provided. Community care workers who obtained Certificate III or IV in Community Services (Home and Community Care) between 1994 and 2000 are considered to have an appropriate qualification for the provision of HACC program funded services, however gap training may be needed to update skills and knowledge.

Vocational training from 2000 onwards

In 1999 for the first time a national Community Services Training Package was introduced. Training packages are regularly revised and qualifications and competency units updated or redeveloped. The qualifications recognised by the Victorian HACC program are listed below.

CHC99 Community Services Training Package

- CHC30199 Certificate III in Community Services (Aged Care Work)
- CHC40199 Certificate IV in Community Services (Aged Care Work)

CHC02 Community Services Training Package

- CHC30202 Certificate III in Home and Community Care

CHC08 Community Services Training Package Version 3

- CHC30308 Certificate III in Home and Community Care
- CHC40208 Certificate IV in Home and Community Care

CHC08 Community Services Training Package Version 4

- CHC30312 Certificate III in Home and Community Care
- CHC40212 Certificate IV in Home and Community Care

The Certificate IV in Home and Community Care can be either an entry level qualification or it can be the next level of training for those who already have a Certificate III qualification. It has electives recommended for advanced care work which is the relevant training for HACC community care workers along with the compulsory units and electives recommended for service coordination work for those who wish to start training in service coordination. These are two distinct job roles.

In the Community Services and Health Industry Training Packages the term service coordination means the job role of coordinating a service. It does not refer to the service coordination policy and practice as described in the *Better access to services framework* (2001), the *Victorian service coordination practice manual* (2012) and the Service Coordination Tool Templates.

The electives recommended for service coordination work do not qualify staff to do community care work with service users. A community care worker who has a Certificate III qualification may wish to do Certificate IV in Home and Community Care with the electives recommended for service coordination job roles because they wish to do this job role.

Personal care competencies and training

Where personal care tasks are undertaken by HACC funded community care workers they must be provided in accordance with the HACC Personal Care Policy.

The HACC Personal Care Policy is included in Part 3 of this manual and describes the required competencies for personal care, first aid, medication assistance, foot care and oral hygiene. These competency units are drawn from the CHCO8 Community Services Training Package and are part of the qualifications listed above for community care workers. However as some of these competency units are electives not all community care workers who hold one of the above qualifications would have all of the relevant competency units.

The policy also outlines the requirements in relation to:

- transferable skills, that is, those which are gained as part of a qualification and competencies, and which can be used with multiple people receiving HACC services
- non-transferable skills, that is, those which are specific to an individual and cannot be used with another individual.

Refer to the HACC Personal Care Policy in Part 3.

Food Safety

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.

Competency-based gap training for all staff

Gap training refers to competency-based training provided to new or existing staff who have a qualification but need to develop competency in one or more areas.

HACC managers are responsible for identifying and organising appropriate gap training for new and existing staff. See examples below.

- A newly recruited community care worker has completed a Certificate III in Home and Community Care but did not complete one or more of the elective competencies their employer requires or they have a partly relevant qualification such as Certificate III or IV in Aged Care, Certificate III or IV in Disability.
- Existing community care workers may require gap training to address areas of competence, which may have not been gained through previous qualifications or training, such as food safety, personal care, first aid, or assistance with medication.

- VET system changes such as the development of new competency units. This particularly applies to people who have completed qualifications prior to 2003.
- To address occupational health and safety requirements for staff who work substantially in isolation from other staff, HACC assessors may complete HLTF311A Apply first aid, with updates in accordance with the Australian Resuscitation Guidelines.
- HACC assessors who do not have a clinical qualification such as nursing may only undertake personal care assessment for people who have stable health and are not considered to have complex care needs. Depending on their individual learning needs, assessors may benefit from the following Level IV competency unit to increase their knowledge of personal care: CHCICS401B Facilitate support for personal care needs.
- A newly recruited community care worker in a planned activity group is required to assist with personal care, and has the minimum requirement of a Certificate III level qualification but has not completed the required personal care and first aid competency units. The person is required to complete these before providing personal care to the planned activity group participants. The relevant first aid and personal care competency units from CHC08 Community Services Training Package Version 4 are: HLTF311A Apply first aid and either CHCICS301B Provide support to meet personal care needs; or CHCICS401B Facilitate support for personal care needs.

Other education and training

Orientation and induction, inservice training and informal learning which is provided through a variety of delivery modes will assist to ensure a skilled workforce that can deliver high-quality services. These complement higher education and vocational education and training.

Orientation and induction

All newly appointed HACC staff members should participate in a planned and managed orientation and induction program. Organisations have the responsibility to ensure that staff funded by the HACC program are oriented and inducted including the relevant requirements in relation to this policy manual and the HACC quality framework.

Orientation is the process of introducing and welcoming a new employee to the organisation and developing their initial organisational knowledge, skills and attitudes to underpin the effective implementation of their role.

Induction is the staff member's initial introduction to a new job role and will vary according to the position and the individual's skills, knowledge, experience, role and responsibilities.

Organisations should regularly review and update their orientation and induction programs.

Inservice training

Access to inservice training which does not result in a qualification or competency, is important to enhance, extend and refresh skills and knowledge.

For example, inservice training may be beneficial in relation to:

- HACC program policies and requirements
- Community Care Common Standards guide, HACC statement of rights and responsibilities and Victorian HACC Program Complaints Policy
- occupational health and safety issues
- infection control practices
- manual handling and the safe use and maintenance of equipment
- active service model approach and person-centred care
- service coordination
- diversity planning and practice
- specific disabilities or mental health issues
- specific health conditions, such as dementia or chronic disease management
- healthy ageing, physical activity, nutrition and emotional wellbeing.

Inservice training should be based on a process of regular training needs assessment, and occur in the context of a training plan, to optimise the opportunities for HACC staff to benefit.

Informal learning

Informal learning approaches can assist staff members to further develop their knowledge and skills and reflect on their practice. Approaches such as mentoring, buddying, shadow shifts with an experienced worker, case presentations and case reviews are examples of informal learning approaches.

HACC funded organisations are encouraged to ensure that staff members have access to a range of informal learning opportunities to complement the more formal education and training requirements.

Links

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

Community Care Common Standards (CCCS) guide (Commonwealth Department of Health and Ageing 2010) <http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-publicat-commcare-standards.htm>

Community Services and Health Industry Skills Council <https://www.cshisc.com.au/index.php>

HACC Living at home assessment <http://www.health.vic.gov.au/hacc/assessment.htm>

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

Service coordination online learning <http://www.health.vic.gov.au/pcps/workforce/index.htm>

Supervision and delegation framework for allied health assistants (Department of Health 2012). www.health.vic.gov.au/workforce

Victorian HACC Education & Training Service <http://hacc.chisholm.edu.au>

Pre-employment checks

Departmental service agreements with HACC funded organisations require that pre-employment/pre-placement checks should be made for all staff (paid or unpaid) and students who have any contact with people using services.

The word student refers to a vocational student aged 18 years and over only, such as a student undertaking the Certificate III in Home and Community Care, a social work student or an occupational therapy student.

The purpose of pre-employment checks is to verify the applicant's identity and credentials, including formal educational qualifications and to determine their suitability for the duties of a position.

All employees, volunteers and vocational students must be aged over 18 years. The forms of pre-employment checks for positions that have contact with people using services should include proof of identity, age, qualifications, referee checks and police checks.

Police Record Check

In Victoria HACC staff, volunteers and vocational students on placement must undergo a Police Record Check.

The following information is taken from *Service agreement information kit* section 4.6, 'Police Record Check Policy (including Working with Children Check)'.

The policy provides a list the circumstances or persons where a Police Record Check is required. The circumstances include either actual unsupervised contact with clients, or the potential for such unsupervised contact.

Police Record Checks can be obtained directly from Victoria Police or through an authorised service or agency accredited by CrimTrac. CrimTrac is the national information sharing service for Australia's police, law enforcement and national security agencies.

Current information on the cost of obtaining a Police Record Check can be obtained from the Victoria Police website.

Applicants and funded organisations conducting Police Record Checks may be able to access reduced fees for checks on volunteers and students on placement.

Police Record Check documentation (including consent forms, proof of identity documentation and records checks) should be used and stored in accordance with the *Information Privacy Act 2000* and any contractual requirements with the CrimTrac accredited agency.

For details see *Service agreement information kit* section 4.6, 'Police Record Check Policy (including Working with Children Check)'.

Commonwealth police check requirements for package care providers

The *Aged Care Act 1997* has different requirements for Commonwealth funded package care programs compared to Victoria. The major difference between the two is that the Commonwealth requires a police check to be conducted every three years.

Where a funded organisation provides both HACC services and Commonwealth packages, the funded organisation may wish to consider applying the Commonwealth requirement to both HACC and Commonwealth funded services. This will meet all program requirements and streamline internal organisation processes.

Full details on the Commonwealth requirement can be found on the Commonwealth's web site.

Working with Children Check

The following information is taken from section 4.6 of the *Service agreement information kit*: 'Police Record Check Policy (including Working with Children Check)'.

The *Working with Children Act 2005* introduced mandatory screening processes for people who volunteer or work with children.

From 1 July 2006, organisations receiving funding from the Department of Human Services or the Department of Health are responsible for ensuring that employees or volunteers undergo a Working with Children (WWC) Check if required. Section 9 of the Working with Children Act identifies which employees or volunteers require a WWC Check.

For details see the *Service agreement information kit* section 4.6, 'Police Record Check Policy (including Working with Children Check)'.

More information about the WWC Check visit the Department of Justice website or telephone the Working with Children Check Information Line on 1300 652 879.

Students under 18 years of age

Where a HACC funded organisation has school students on a school community services placement it is preferable that this placement takes place in a communal setting, such as a planned activity group.

Primary and secondary school students are not permitted to undertake a school community services placement that includes visits to the home of a person using HACC services.

School students must not be left alone with a person using HACC services and must be supervised at all times.

Consideration should be given to the ability of each student to cope with the placement. A Police Record Check is not required however the school and parents or guardian must ensure that only suitable students undertake a placement.

Links

Commonwealth Privacy Act 1988

<http://www.oaic.gov.au/>

Commonwealth Police Check requirements

www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-factsheet-policechecks-guidelines.htm

CrimTrac

<http://www.crimtrac.gov.au/>

Department of Justice website for information on the *Working with Children Act 2005*

<http://www.justice.vic.gov.au/workingwithchildren/utility/home/>

Health Records Act 2001 (Victoria)

http://www.austlii.edu.au/au/legis/vic/consol_act/hra2001144/

Office of the Australian Information Commissioner

<http://www.oaic.gov.au/>

Privacy Victoria

<http://www.privacy.vic.gov.au/privacy/web2.nsf/pages/contracted-service-providers-and-agents>

Service agreement information kit for funded organisations

<http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement>

Victoria Police

<http://www.police.vic.gov.au>

Privacy and record keeping

This information is taken from the *Service agreement information kit* section 3.17, 'Privacy and Whistleblowers Act (now Protected Disclosure Act)'. You should read this section in its entirety.

The department and funded organisations are subject to a legislative privacy regime that governs the handling of personal and health information. The *Information Privacy Act 2000 (Vic)* (IPA) and the *Health Records Act 2001 (Vic)* (HRA) protect personal and health information by setting standards on how such information should be handled, from collection to disposal.

The IPA covers personal information, other than health related information, held by Victorian public sector organisations. The HRA covers health information handled by both public and private sector organisations.

It is expected that organisations have a privacy policy and procedures that incorporate the principles in the Victorian privacy legislation as minimum standards for handling personal and health information. Broadly, this means organisations should:

- collect only information which is needed for a specified primary purpose
- ensure clients know why information is collected and how it will be handled
- use and disclose the information only for the primary or a directly related purpose, or for another purpose if authorised by law
- store the information securely and protects it from unauthorised access
- retain the information for the period required by the *Public Records Act 1973*
- provide the person with access to their own information and the ability to correct incorrect information.

Funded organisations are required under the service agreement to comply with both the IPA and HRA. Funded organisations handling health information are directly subject to the HRA.

The principles in the privacy legislation can be found in the *Information Privacy Act 2000* and in the *Health Records Act 2001*. Copies can be purchased from Information Victoria telephone 1300 366 356.

The Privacy Victoria website provides information for organisations on their responsibilities under the Information Privacy Act. With regard to the Commonwealth Privacy Act, the Privacy Victoria website states:

Although some service providers may be subject to the National Privacy Principles (NPPs) under the *Commonwealth Privacy Act 1988*, if the service provider is carrying out obligations under a state contract it must comply with the Information Privacy Act (and the IPPs) rather than the NPPs under the Privacy Act.

However, it should be noted that the NPPs and Victorian IPPs are quite similar. Organisations that are required to comply with the NPPs should have little difficulty adapting compliance to the Victorian IPPs

For details see *Service agreement information kit* section 3.17, 'Privacy and Whistleblowers Act (now Protected Disclosure Act)'.

Please note that on 10 February 2013 the *Protected Disclosure Act 2012* came into effect replacing the Whistleblowers Protection Act.

Duty of care

A duty of care is a duty to take reasonable care of a person. It is a general legal standard that people receiving HACC services have a right to expect that people in funded organisations providing HACC services possess the necessary skills and knowledge to provide that service. People receiving HACC services also have the right to expect that all those who provide care will take reasonable action to avoid harming them, and to protect them from foreseeable risk of injury.

All paid staff members, volunteers and students owe a duty of care to the people they are providing a service to, and are responsible and independently accountable for their actions at all times. Nurses and allied health staff providing HACC services are therefore obliged to use their expert judgement in regard to the delegation of aspects of a person's care to a HACC community care worker.

HACC funded organisations have a duty of care to anyone who is reasonably likely to be affected by their activities. These people may include:

- the person using HACC services, including their families and carers
- certain groups of people in the community who may be indirectly affected by HACC activities, for instance, members of the public who are participating in the same community activity as a group of people using HACC services
- paid staff, volunteers and students.

Funded organisations must take reasonable care to avoid causing injury to these categories of people in the delivery of HACC services.

Levels of employees

Duty of care can be owed by different levels of employees in any particular situation. HACC program directors, service managers, team leaders, supervisors, community care workers and health professionals will all have a duty of care to the groups of people listed above. In any particular situation, each of these employees will be expected to do different things to ensure their duty of care is not breached.

HACC funded organisations should ensure that all paid staff, volunteers and students are aware of their duty of care responsibilities and provide support to employees in this duty. Types of support include staff discussion about the issue, providing written information on duty of care, specific duty statements, policies and procedure documents and training.

Funded organisations should also refer to the relevant legislative requirements inherent in the *Occupational Health and Safety Act (Victoria) 2004* to which all employers are bound.

Regulatory bodies such as the Australian Health Practitioner Regulation Agency may also take action when duty of care has been breached.

A breach of duty of care

A duty of care is breached if a person behaves unreasonably. Failure to act can also be unreasonable in a particular situation. The 'reasonableness' of what a person has done, or not done, is legally assessed, in court, by considering how a hypothetical reasonable person would have behaved in the same situation. When making decisions about the 'reasonableness' of any action, the following factors must be taken into account:

- the risks of harm and the likelihood of the risks occurring
- the types of injuries that may occur, and how serious they are
- the precautions which could be taken
- the powers which employees have
- the usefulness of the particular activity which involves risks
- any statutory requirements or specific directions from the department
- current professional standards about the issue.

Any other factor that is relevant in a particular situation must also be taken into account. The factors all need to be considered together to determine what is reasonable. No single factor can be relied upon to justify acting in one way rather than another. Staff must use their skills in decision making, noting that a person's consent does not justify acting unreasonably. If there is a real risk that someone will suffer serious harm and there are no reasonable and effective precautions possible, then the activity must not be undertaken.

Negligence

Negligence is defined by three elements, duty of care, breach of duty of care and injury. All three elements must be present in any situation for the department or the organisation to be considered negligent by a court.

- Duty of care — the department or funded organisation must owe a duty of care to a particular person.
- Breach of duty of care — the department or funded organisation must have done something a reasonable person would not have done in a particular situation. Conversely, the department or funded organisation must have omitted to do something which a reasonable person would have done. Some harm must have been caused to the person as a result of the department or funded organisation's unreasonable action.
- Injury — there must have been some harm caused by the department or funded organisation's breach of duty of care. The only types of injury currently recognised by the courts are physical injury, nervous or emotional shock and financial loss. Unless a person suffers one of these types of injury there will not have been any negligence by the department or funded organisation as recognised by law.

Occupational health and safety

Occupational health and safety (OHS) is an important consideration for all HACCC funded organisations. The fundamental nature of HACCC services means that there are many challenges to the effective management of OHS. This is because all people have individual and diverse needs, services may be delivered in a person's home environment, and in some situations specific training will be necessary to meet the needs of people using HACCC services.

An employer has a broad duty or responsibility to provide and maintain, so far as is reasonably practicable, a safe and healthy working environment for its employees. A working environment is a broader concept than the physical workplace. It includes:

- the machinery and substances used at the workplace
- the work processes including what is done and how
- work arrangements including hours of work
- the intangible environment including the presence of stress factors such as staffing levels and harassment by fellow employees, people using HACCC services.

Central to the employer's duty is the need to ensure that a workplace under the employer's control and management is maintained, so far as is reasonably practicable, in a condition that is safe and without risks to health.

Key points

An employer has primary responsibility for OHS in the workplace and what happens there. Key points are summarised below.

- Occupational health and safety obligations cannot be contracted out, and the principal employer has obligations, not only to its employees, but also to a contractor and their employees.
- Occupational health and safety responsibilities are based on the degree of effective control that the employer can exercise regardless of the number of contractors and subcontractors involved. The degree of control that can be exercised in a private home that is a workplace is relevant consideration.
- An employer is required, under s. 22(2)(b) of the *Occupational Health and Safety Act 2004* (Victoria), so far as is reasonably practicable, to employ or engage suitably qualified persons in relation to OHS, who can provide advice to the employer in relation to the occupational health and safety of the employer's employees.
- An employer has to ensure persons including visitors, members of the public and other contractors are also protected.
- Information about hazards (for example pets, condition of house) and risk controls must be passed to those who will be exposed to them.
- An employer must, so far as is reasonably practicable, monitor both the health of its employees and the conditions at any workplace under the control and management of the employer.
- An employer implements risk controls having regard to its employees' responsibilities, which are to cooperate with the employer to operate safely and not to put themselves or others at risk.

An example of these responsibilities is shown below (in Table 2) in relation to the provision of in-home services.

OHS for home care services

As described, contemporary occupational health and safety practice is based on identifying workplace hazards, assessing risks and then controlling risks as far as is reasonably practicable.

The majority of HACCC services are provided in people's homes. Living at home assessments and service specific assessments should include the observation and recording of OHS risk information and development of an OHS plan prior to the commencement of in-home services.

Where service provision occurs in employer controlled settings, addressing occupational health and safety issues will not be so closely aligned with the process of service user assessment, but usually addressed by implementing universal precautions.

The table below illustrates typical steps in assessment and care planning and how this might impact on OHS issues.

Table 1: Example of OHS responsibilities during care pathway (Victorian Home Care Industry Occupational Health and Safety Guide, Department of Human Services and WorkCover Authority 2005)

Care pathway stage	OHS impacts
Referral	Transfer of available OHS related information
Needs assessment	Indication of possible OHS issues
Home safety assessment	Assessment of working environment
Care plan	Allocation of OHS responsibilities, OHS plan
Assignment of home care worker	Training and information for home care worker
Equipment to assist	Suitable equipment to reduce risks
Client services	Worker and client safety

Table 2: Example of OHS responsibilities for in-home services (Victorian home care industry occupational health and safety guide, Department of Human Services and WorkCover Authority 2005)

Responsibility	Typical OHS responsibilities	Examples for in-home services
HACC funded organisation	<ul style="list-style-type: none"> Assess risks in provision of service Consult with staff members Provide training Assess OHS capability of subcontractors Ensure service does not create risks to others (for example person using service, family, friends) Monitor OHS issues 	<ul style="list-style-type: none"> Home safety check Regular discussion about care plan Training in-home safety checklist OHS standards to be met by potential contractors Inclusion of person being assessed (and carer) in risk assessment process Regular reassessing of the person's support requirements
Community care worker	<ul style="list-style-type: none"> Follow procedures for safe working Report incidents and injuries Present fit for duty 	<ul style="list-style-type: none"> Follow safety procedures in care plan Advise of incidents and injuries using supplied forms Comply with any alcohol and other drugs policy
Contractor	<ul style="list-style-type: none"> Follow procedures set by managing organisation Apply specific prevention measures for the tasks contracted 	<ul style="list-style-type: none"> Meet OHS standards in service agreement Manage hazardous substances used in major property clean ups
HACC eligible person (including carer)	<ul style="list-style-type: none"> Inform service provider of any known hazards Make changes to home environment to minimise risk to community care worker 	<ul style="list-style-type: none"> Advise funded organisation of faulty equipment Secure pets where necessary Refrain from smoking while community care worker is present
Volunteers	<ul style="list-style-type: none"> No responsibilities under OHS law but common law duty of care to person (including carer) 	<ul style="list-style-type: none"> Follows OHS procedures of the funded organisation

OHS plan

An OHS plan should be developed following the home safety assessment. This plan should include assessment of tasks involved, controls to manage the risks and the provision of suitable equipment. This forms part of the person's care plan.

Depending on business rules of the organisation, the home safety assessment may be conducted by the community care worker at the beginning of the first service visit and the care plan amended following this. Refer to the *Victorian home care industry occupational health and safety guide October 2005*, pp. 18–20 for a home safety inventory template.

Duty of care

It is recognised that HACC funded organisations will also owe a duty of care to those for whom they are providing HACC services, both at common law and sometimes under statute. The *Occupational Health and Safety Act (Victoria) 2004* does not require a service organisation to sacrifice the interests of one party for the other. A funded organisation must, so far as is reasonably practicable, ensure the safety of both the worker and the person receiving the service. Where possible, conflicts need to be resolved by strategies that do not disadvantage either party.

The employer general duty of care requires a judgement to be made about what is reasonably practicable to ensure health and safety, with the context of:

- the likelihood of the hazard or risk concerned eventuating
- the degree of harm that would result if the hazard or risk eventuated
- what the person concerned knows, or ought reasonably to know, about the hazard or risk and any ways of eliminating or reducing the hazard or risk
- the availability and suitability of ways to eliminate or reduce the hazard or risk
- the cost of eliminating or reducing the hazard or risk.

In addition to the duties owed by an employer to its employees and contractors, an employer must ensure, so far as is reasonably practicable, that persons other than its employees and contractors are not put at risk by the employer's undertaking. Such persons include the person using HACC services, family carers, volunteers, members of the public and visitors to premises at which the employer is carrying out its undertaking.

Community venues

Centre-based meals, planned activity groups and carer support groups most commonly take place in a venue other than a person's home. Other HACC services may also require a community venue for service provision.

Community venues (including those owned by the HACC funded organisation) should be of a user-friendly design, domestic in scale and non-threatening.

Venues should be relevant to the service being provided and target group, and should be designed and managed in a way that maximises physical access.

When a location is needed for a new or existing service, HACC funded organisations should consider all existing community venues, especially those that receive HACC funding. For example, senior citizen centres, community centres or neighbourhood houses.

Key considerations in selecting a community venue include:

- appropriateness, in terms of scale and ambience, to the nature of the service to be provided, for example, a carer support group may require a different meeting venue style and size compared to that required by a planned activity group
- the characteristics of the people using the service, for example, people with dementia may require a secure setting with a low level of ambient noise which is designed to avoid unnecessary disorientation or confusion

- facilitating community access and inclusion, for example, easy access to shopping centres, recreational services, public conveniences, public transport and other community facilities
- physical accessibility in accordance with disability access standards
- a positive sensory environment to contribute to participants' sense of emotional wellbeing
- location in a typical community setting in the consumers' local community or with a subregional or regional focus to reflect broader communities of interest for example CALD communities
- staff and volunteer occupational health and safety requirements.

With the exception of centre-based HACC nursing and allied health, where a clinical setting is needed to meet health regulations, a medical setting is generally not appropriate for providing HACC services. Residential care/institutional settings and large halls with a stage are also not suitable for community based HACC services.

Transport provision by paid staff or volunteers

The Victorian approach is to incorporate meeting the transport needs of HACC clients into a range of funded services including domestic assistance and personal care: for example, by taking people shopping, bill paying and to other activities; through PAGs by transporting people to the PAG centre or providing the transport for outings; and through Volunteer Coordination by funding transport provided by volunteers.

Service providers should take reasonable care to ensure the safety of all concerned where paid staff or volunteers are providing transport or escort services.

It is the responsibility of the service provider to ensure they are meeting their OHS responsibilities for safe driving and client transport practices. These responsibilities are outlined in section 5.2.5 of the *Victorian Home Care industry Occupational Health and Safety Guide* (2005).

Links

Home care: occupational health and safety compliance kit — how to control the most common hazardous tasks in the home care sector (WorkSafe Victoria 2011)

http://www.worksafe.vic.gov.au/__data/assets/pdf_file/0003/8571/Home2Bcare2BOHS2Bcompliance2Bkit5B15D_June_2011.pdf

Victorian home care industry occupational health and safety guide (Department of Human Services and the Victorian WorkCover Authority 2005)

http://www.health.vic.gov.au/hacc/downloads/pdf/vic_homecare.pdf

WorkSafe Victoria

<http://www.worksafe.vic.gov.au/>

Working safely in visiting health services (WorkSafe 2006)

<http://www.worksafe.vic.gov.au/wps/wcm/connect/wsinternet/WorkSafe>

Program funding

Organisations eligible to provide HACC services include local governments, community organisations, religious and charitable bodies, health agencies and private (for profit) organisations.

HACC funds are allocated to an organisation through a service agreement between the funded organisation and the department or via a statement of priorities (SOP) if the organisation is a health service. The service agreement or SOP specifies the terms and conditions of funding including the targets and funding by activity.

The service agreement includes provisions allowing organisations to subcontract services, in whole or in part, to a third party. This can only happen with the prior written consent of the department.

Funds may only be used for the purpose for which they have been provided. Performance is subject to review and monitoring. Performance outside the five per cent tolerance may be subject to risk management procedures including recoupment.

All HACC funded organisations have the capacity to adjust the mix of services they provide in response to service planning and/or changing community or local needs. Renegotiation is cost neutral and is not an opportunity to receive new funds. All renegotiations are effective as of 1 July the following financial year. They do not affect the current financial year.

Any formal variation to the use of funding must be agreed between the funded organisation and the department in writing or through the renegotiation process.

HACC funds cannot be used for non-HACC purposes.

HACC funds are allocated to an organisation not to a person. If a HACC client relocates or chooses to access services from another organisation, HACC funds cannot be transferred to them or to the other organisation. These funds are then released for use with other clients of the funded organisation.

Funded organisations are required to comply with the service agreement terms and conditions. The *Service agreement information kit for funded organisations* outlines requirements such as the financial reporting requirements, subcontracting and insurance.

In addition to direct funding from the department, all HACC funded agencies are required to operate in accordance with the fees policy. This means that organisations must charge a fee to all people assessed as having the capacity to pay. Income raised through fees is used to provide additional hours of service or to enhance service provision.

How funding is determined

HACC activity is funded through a Victorian HACC unit price or negotiated block funding.

Where an activity is targeted to client services and can be clearly described and defined, a common price can and has been developed. This is the Victorian unit price.

Where an activity is unique to each organisation and is negotiated separately with each organisation and the department, a common unit price cannot be developed and the activity is block funded. This includes pilots.

What is included in the HACC unit price or defined contribution?

Included in the unit price is all direct and indirect costs incurred by the funded organisation:

- staff and associated costs (such as salary and on-costs, supervision, inservice training and induction)
- staff travel
- some consumables, for example podiatry needs, pens and paper (however, please note that where consumables are deemed to be program costs such as entertainment at a planned activity group, the costs are borne by the person through the contribution from the person to the program — this is over and above the fee)
- operational support and management costs (overheads).

HACC funding does not cover the cost of education and training including qualifications for staff employed in HACC services. Funding for education and training is the responsibility of the vocational education and training system and the higher education system.

A price or defined contribution applies to the following HACC activities:

- assessment
- allied health
- nursing
- access and support
- domestic assistance
- personal care
- respite
- property maintenance
- planned activity groups
- volunteer coordination
- linkages
- delivered meals.

The service agreement shows the organisation's output targets and the corresponding funds for unit-priced activities based on the unit price.

What can be counted towards an agency target depends on the type of activity being delivered.

Assessment, allied health, nursing and access and support

An hour of service comprises:

- time spent in direct face-to-face contact with the person
- indirect time spent on behalf of the person such as:
 - phone calls with the carer and family or other organisations
 - time spent writing case notes, sending referrals and care coordination.

For more information refer to the counting rules documents for specific HACC activities such as 'assessment' and 'access and support'.

Domestic assistance, personal care, respite and property maintenance

An hour of service comprises:

- time spent by the community care worker in face-to-face contact with the person
- time spent in essential activities such as shopping as part of domestic assistance, and purchasing materials and construction for property maintenance
- telephone calls to the person, for example telephoning the person on a heatwave day.

Planned activity groups

A person hour comprises:

- the hours of face-to-face contact with each person attending the group. For example, five people attending a four-hour group will constitute 20 hours of planned activity group
- bus trips where the trip to and from the program comprises part of the program because there is a program coordinator on the vehicle to provide and guide the program on the bus. In this circumstance time travelling to and from the program can be counted.

Meals provided at a planned activity group do not attract a meal subsidy because most planned activity group (PAG) programs are provided around a mealtime and food is included in the planned activity group unit price.

However, 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.

Volunteer coordination

The service agreement has two targets under volunteer coordination. The first and key output-measure target is the number of hours the volunteer coordinator works. The second target (mandatory since 1 July 2013) is to identify the number of hours of service provided to people by volunteers.

An hour of coordinator time comprises:

- all activity undertaken by the paid worker.

An hour of service to people comprises:

- hours of face-to-face contact with people by volunteers
- for some programs it also includes hours of face-to-face contact with volunteers by the volunteer coordinator.

An organisation receiving volunteer coordination funding may also receive block funding through 'Volunteer coordination other'. This funding can be used to cover additional costs, such as:

- volunteer recruitment and training
- newsletters
- Police Record Checks and Working With Children Checks for volunteers
- volunteer reimbursements
- the cost of telelink connections.

Linkages

A linkages package is a package of services provided to a person.

Linkages package subcontracting is endorsed in the 'Linkages activity statement' in Part 3 and therefore does not require the written consent of the Department of Health.

Meals

The delivered meal subsidy provides a **small top-up contribution** towards the cost of home-delivered meals and meals provided at venues. The major component of the meal cost is met by the person through their contribution and may be further supplemented by a contribution from the agency.

A meal comprises of a meal or meals delivered to a home or provided in a community setting.

Meals provided to a PAG cannot be counted as the cost of the meal is paid by the PAG.

Block funding

Block funding applies to flexible service response, service system resourcing, 'Volunteer coordination other', and some types of nursing.

The amount of money to be paid to the organisation is negotiated between the provider and the department on a case-by-case basis.

Where the activity is provided to people and there is a close match to a unit-priced activity or a defined subsidy, the agency may report the outputs on the minimum data set (MDS) using standard counting rules.

Where the activity can be readily quantified the agency may negotiate a target with their PASA — for example the number of senior citizen centres that the funding supports or the number of continence sessions a continence nurse will provide.

In all other cases the region and agency negotiate an appropriate workplan which is then reported against through the annual service activity report.

Other funding

Other funding may be available from time to time. Examples include service development funding, or minor capital funding. These are one-off payments and where appropriate specific reporting requirements will be negotiated.

Performance monitoring

Normally an organisation is expected to be within five per cent of target for each activity. If organisations do not meet target they:

- will be performance managed by the regional PASA
- may not be considered for growth funds for that activity
- may risk withdrawal of funds as per the HACC recall policy described in section 2.12 of the *Victorian health policy and funding guidelines 2013–14* part 2 'Health operations'.

Unit prices and defined contributions

The schedule of HACC unit prices and defined contributions are indexed and updated annually to be effective from 1 July.

The schedule of fees and income levels are updated and indexed in January of each year following the Commonwealth update of Centrelink income band ranges.

Reporting requirements

Using the HACC minimum data set, HACC funded organisations report quarterly to the department on outputs achieved as per their service agreements and targets. The reports are collated and aggregate information is sent to the Victorian Department of Treasury and Finance.

Other reporting requirements are negotiated on a case-by-case basis for block-funded activities and reported annually in June.

Other requirements such as the financial reporting requirements are outlined in the *Service agreement information kit*.

Links

Service agreement information kit for funded organisations
<http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement>

HACC Recall Policy described in *Victorian health policy and funding guidelines 2013–14*, part 2 'Health operations' <http://www.health.vic.gov.au/pfg/operations.htm>

The schedule of HACC unit prices and defined contributions
http://www.health.vic.gov.au/hacc/prog_manual/downloads/unit_prices2012.pdf

Program planning

Triennial and growth funding planning

The Victorian HACC triennial plan 2012–15 is a three-year statement of the priorities and strategic directions for the HACC program.

Through the triennial plan the Victorian minister responsible for aged care sets key priorities for the allocation of HACC growth funds in Victoria, which are then approved by the Commonwealth minister responsible for aged care. The allocation of HACC growth funds for any particular year is described in the *Victorian annual supplement* and informed by the strategic directions agreed in the triennial plan.

A regional consultation process initiates the annual growth funding allocation process. The consultation provides an opportunity for the region to discuss with the service sector:

- progress against priorities
- emerging trends for service delivery
- pressure points in the system.

Once the quantum of new funds by local government area has been identified, the region uses a range of data sources to underpin recommendations for the allocation of growth funding, including:

- outcomes of the regional consultation
- service performance and Community Care Common Standards quality reviews
- census data of the HACC target population or the need for assistance measure (NAM)
- local pressures and service demand.

The regional recommendations are consolidated to create the *Victorian annual supplement* that is approved by both the relevant state and Commonwealth minister.

Planning interfaces

The HACC program is part of a broad service system of community, health and welfare services that include:

- community health services
- disability services
- Aged Care Assessment Services (ACAS)
- Commonwealth Home Care Packages
- National Respite for Carers Program
- Victorian Support for Carers Program (SCP)
- dementia services
- other health and community programs.

Planning for HACC services takes into consideration the broader service system.

Departmental Advisory Committee

Departmental Advisory Committee on the HACC program

The HACC Departmental Advisory Committee (DAC) provides strategic and policy advice and information to the department in relation to HACC services for older Victorians, younger Victorians with a disability, and their carers.

The HACC DAC is the main advisory and consultative mechanism for the HACC program in Victoria and has wide representation from service provider organisations, consumer representative organisations, and the Commonwealth Departments of Social Services and Veterans' Affairs. The DAC meets quarterly and convenes specific working groups as required.

Reporting requirements

The state government reports quarterly and annually on the outcomes of the HACC program.

Using the HACC minimum data set, HACC funded organisations report quarterly to the department on outputs achieved as per their service agreements and targets. The reports are collated and sent to the Victorian Department of Treasury and Finance.

HACC funded organisations report on block funding through the annual service activity report.

The department provides an annual business report to the Commonwealth by 31 December each year. This report includes information on regional expenditure, service outputs and service quality against the service priorities and outputs specified in the Victorian HACC program annual plan. The business report is tabled in Federal Parliament.

Links

Victorian HACC triennial plan 2012–15 (Department of Health 2012)

http://www.health.vic.gov.au/hacc/plan_fund/downloads/triennial_plan_12-15.pdf

Reporting and data collection

Introduction

All HACC service providers are required to participate in two kinds of data collection:

- the HACC minimum data set (reported quarterly)
- the HACC fees report (reported annually).

Depending on an organisation's service agreement, the following may also be required:

- an annual service activity report
- other narrative reports, quarterly or annually.

Reporting requirements are set out in every organisation's service agreement with the department.

The HACC minimum data set

As a condition of funding, most agencies funded by the HACC program are required to participate in the regular collection of the HACC national minimum data set (MDS).

The scope of the HACC MDS in Victoria covers a small number of programs apart from HACC. Agencies funded by the following programs should use the HACC MDS to report to the department:

- HACC program
- Aged Care Support for Carers Program
- Community Connections
- Housing Support for the Aged
- Older Persons High Rise Support
- SRS Service Coordination and Support Program.

The HACC MDS comprises two critical kinds of information on individual people:

- demographic information, such as age, postcode, country of birth, and living arrangements
- service usage information, being the time (hours or minutes) or amount (meals or goods/ equipment) of each service type received by the person in the preceding three months.

Organisations use their choice of software system to collect and store this information. When a person becomes a client of the organisation, a record is created and kept updated.

At the end of the quarter, the organisation should have a routine process to extract the required subset of de-identified data and email it to the department.

As soon as a file of data is received, an acknowledgment is emailed back to the organisation. The department then loads the files onto a data repository. While processing the files the repository sends further feedback to the agency in the form of a submission log.

All the data submitted is collated and used at an aggregate level for reporting to state and commonwealth governments and to monitor the effectiveness of the program.

Individual people are never identified and the information is not used by government to determine a person's eligibility for services.

Feedback is also available within days of submission on the department's Funded Agency Channel. Other reports and fact sheets are periodically published on the HACC website.

For detailed information on HACC MDS see the *HACC MDS user guide: Victorian modification version 2.0*

Due dates

Quarterly HACC MDS extracts should be emailed to the department's mailbox (details below) as follows:

- period July–August–September: due 15 October
- period October–November–December: due 15 January
- period January–February–March: due 15 April
- period April–May–June: due 15 July.

Retrospective submission periods occur twice a year, in March and August, when agencies can replace any wrong or incomplete data from previous quarters by submitting new extracts for the relevant quarters.

How to collect the HACC MDS

Agencies should collect the data as a by-product of their existing client information management systems. Several software products are available commercially and enable the HACC MDS to be conveniently collected, extracted and transmitted in the correct format. A list of software products can be found on the data collection page of the HACC website.

The department has a simple reporting tool available which can be supplied to some funded agencies as appropriate.

Counting rules

Since HACC funding for major activity types is on the basis of unit prices, there is a direct link between the level of funding and the hours of service in an organisation's performance targets. The MDS is therefore an important accountability tool for monitoring performance. See Part 1: Program funding for more information on unit pricing and what is counted in an hour of service for different HACC activities.

Know your targets: the Funded Agency Channel

The Funded Agency Channel (FAC) is a website maintained by the Department of Health and the Department of Human Services where each funded organisation can view its service agreement and other relevant information.

Each HACC organisation is able to view a series of reports on the data they submit. One of these reports shows the number of hours or amount of services delivered compared to the organisation's target for each service type. All organisations are expected to be within 5 per cent of their target.

Other reporting requirements

Annual service activity report

Any organisation receiving HACC funds for block-funded activities is required to submit an annual service activity report. A template for the report is emailed to the organisation by the regional office. The completed form must be emailed back to the regional office before the due date in June.

The report is required if your organisation received HACC funds under the following headings:

- 'Flexible service response'
- 'Service system resourcing'
- 'Volunteer coordination-other'.

The report can also be used if an organisation wishes to supply additional information on the use of funds that could not be adequately captured in the HACC minimum data set.

For example, some allied health funding may have been used for secondary consultations undertaken by an allied health practitioner. Such information cannot currently be captured by the MDS unless a new record is created for the person on whose behalf you have supplied a secondary consultation.

The annual service activity report can be used to report on numbers of hours and people benefiting from secondary consultations.

The annual fees report

The annual fees report is a simple one-line report on the total amount of fees collected by an organisation from HACC service users in the relevant financial year.

The completed form is sent to the relevant regional office of the department by 1 October. The department includes the statewide total as part of Victoria's annual HACC business report to the Commonwealth.

Links

The HACC data help desk: phone 9096 7255 or email haccmds@health.vic.gov.au

Email for sending HACC MDS data haccmds.data@health.vic.gov.au

The HACC data collection page of the Victorian HACC website, which includes the HACC MDS user guide, FAQs and other documentation http://www.health.vic.gov.au/hacc/data_collection/index.htm

Funded Agency Channel

<http://www.dhs.vic.gov.au/funded-agency-channel>

HACC Fees Policy

Introduction

This section provides a brief overview of the HACC Fees Policy. Readers must go to the HACC website to access the full fees policy and all the relevant documents.

The policy only relates to fees charged to people receiving HACC services. It does not relate to fees charged to people who, for example, are funded through Commonwealth home care packages or through TAC or other compensation funding.

The HACC Fees Policy (included in the *Commonwealth HACC program manual 2012*) provides a framework for the collection of fees in the HACC program.

The Victorian HACC Fees Policy provides more detailed guidance on the application of the Commonwealth's principles and broad guidelines. Compliance with the HACC Fees Policy is compulsory.

The HACC Fees Policy consists of:

- the fees policy itself
- information for service users including the *Income self declaration form (template)* with income ranges updated annually
- the HACC schedule of fees (updated annually).

Approval for alternative systems of fee collection may be sought from the Department of Health. Such approval will only be granted where these systems are consistent with the principles and guidelines contained in this policy.

The fees policy is an integrated approach to setting fees for people using services and service providers. It is to be implemented as a whole and not as individual components. For example, income is only one factor to be used in determining the fee. A service provider that used income as the sole factor would be in breach of the policy.

Principles

Principles governing the fees are as follows:

- Inability to pay cannot be used as a basis for refusing a service to people who are assessed as requiring a service.
- Where fees are to be charged this should be done in accordance with of the HACC schedule of fees appropriate to the person's level of income, the amount of service used, and any changes in circumstances and ability to pay.
- It is not appropriate to charge a fee for some services, due to the nature of service provision or particular targeting policies, for example volunteer coordination, assessment, access and support.
- All agencies should charge the full cost of the service where the person is receiving, or has received, compensation payments intended to cover the cost of care.
- People with similar levels of income (after considering levels of expenditure) and service usage patterns should be charged equivalent fees for equivalent services.
- People with high and/or multiple HACC-service needs are not to be charged more than a specified maximum amount of fees in a given period, irrespective of the amounts of services used.

- Fees charged should not exceed the actual cost of service provision. A separate charge can be applied where there are additional costs for goods or materials utilised in the provision of a service such as home maintenance, or out of pocket costs related to participation in program events.
- Fee collection should be administered efficiently and attempts should be made to minimise the cost of administration.
- The revenue from fees is to be used to enhance and/or expand services.
- Procedures for the determination of fees should be clearly documented and publicly available. The onus is on the service provider to ensure all service users are aware that this information is available.
- Procedures for determination and collection of fees should take into account the situation of special needs groups.
- Assessment of a person's capacity to pay fees should be as simple and unobtrusive as possible, with due regard for their privacy. Any information obtained should be treated as confidential.
- People using HACC services have the right to access an advocate; this applies to the determination of fees.
- People using HACC services and their advocates have the right of appeal against a given fee determination.
- For the purposes of this policy, solicited donations for services are equivalent to fees and are subject to all provisions of this policy. The implementation of this policy cannot be avoided by using the terms 'payments' or 'donations' instead of fees.

Agency fees policy

HACC organisations' procedures for the determination of fees should be publicly available as per the principles above. All people using HACC services should be informed of the fees applicable to them at the time of assessment or commencement of the service. Organisations should provide a written statement regarding the fee to be charged for any service and the payment procedures.

It is necessary to reassess fees if there is a change in circumstances, particularly in relation to the person's financial situation.

The annual fees report

The annual fees report is a simple one-line report on the total amount of fees collected by an organisation from HACC service users in the relevant financial year.

The completed form is sent to the relevant regional office of the department by 1 October.

The department includes the statewide total as part of Victoria's annual HACC business report to the Commonwealth.

Links

The HACC Fees Policy including the *Income self-declaration form* and information for people
http://www.health.vic.gov.au/hacc/prog_manual/downloads/fees_policy.pdf

For current fees effective from 1 January 2012

http://www.health.vic.gov.au/hacc/prog_manual/downloads/fee_schedule2013.pdf

Victorian HACC program manual

Part 2: Eligibility and access



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 2: Eligibility and access

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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.

Eligibility and priority

HACC target group

The HACC target group encompasses 'older and frail people with moderate, severe or profound disabilities, younger people with moderate, severe or profound disabilities, and their unpaid carers'.

Eligibility means that the person is assessed as being in the HACC program target group. Eligible people are then prioritised for service provision.

Services funded by the HACC program are provided to people within the target group after the person has been assessed and their level of need prioritised.

Eligibility for services is not based solely on age, but on the level of difficulty a person experiences in carrying out tasks of daily living.

Activities of daily living include personal care, dressing, preparing meals, house cleaning and maintenance, and using public transport.

Eligibility does not confer entitlement to service provision.

Services may not be able to be provided due to other people being assessed as a higher priority or resources not being available.

Organisations should regularly reassess and prioritise existing service users.

Eligibility and residency or visa status

Access to some government funded services can be restricted due to the immigration residency status or visa type that a potential client may hold.

It is important to remember that there is **no restriction** on access to HACC services based on residency status or visa type.

For further information in relation to assessments, see:

- Part 2: 'Service coordination, assessment and care planning'
- Part 3: 'Living at home assessment'.

Priority

Services are only provided to people in the HACC target group subject to assessment for eligibility and level of priority.

Overall, the HACC program targets its services to people who have the greatest need and/or capacity to benefit from them.

Services are provided where they would not otherwise be available through self-provision, carer and family support or another government program.

Priority is assessed in the context of a person's usual living environment and available supports, in comparison to other eligible people.

Factors such as the person's relative needs and the capacity of service providers to respond with existing resources may mean that services cannot be provided even if the person is eligible.

In order to manage demand, organisations should discuss exit strategies and short-term service use as part of the wellness and restorative approach to HACC service provision.

Organisations should regularly review and reassess people's progress towards achieving their goals and adjust care plans accordingly.

Where demand exceeds service supply, it is the responsibility of the funded organisation to allocate resources in a way that provides the most benefit to the greatest number of people.

Factors to be taken in to account in making this judgement include:

- the level of service to be provided given that the HACC program funds provision of basic maintenance and support
- the vulnerability of the person's health and wellbeing to further deterioration
- the effect of service delivery on carers
- the likelihood that the service will assist the person to attain their goals, for example, reduce the risk of admission to hospital or residential care, or maintain quality of life in the community
- the effect on other people seeking support from HACC services.

If clients or carers feel that they need a higher level of service than the provider can offer at the conclusion of the assessment for priority and service planning, they can request to purchase additional services from the provider.

These requests will be considered based on the organisation's capacity and the availability of staff members to meet the request on a full cost-recovery basis.

Special needs groups

Within the broad HACC target group the HACC Review Agreement 2007 lists five special needs groups who may experience barriers to accessing services.

A person's eligibility for HACC services should be determined before considering whether they belong to a special needs group.

The concept of special needs does not mean that one person is prioritised over others for service provision, but that their diversity should be considered during access, assessment, care planning and service provision.

The special needs groups are people:

- from Aboriginal and Torres Strait Islander backgrounds
- from culturally and linguistically diverse (CALD) backgrounds
- with dementia
- living in isolated and remote areas
- experiencing financial disadvantage (including people who are homeless or at risk of homelessness).

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

Links

HACC Review Agreement

<http://www.health.gov.au/internet/main/publishing.nsf/Content/hacc-review.htm>

Diversity

Diversity planning and practice

The Victorian HACC program is committed to respecting the diversity of the Victorian population.

The program works to remove perceived or actual barriers to care and support for those who need it, so that they can remain living independently in their homes and communities.

In accordance with this commitment, the HACC program has implemented a policy of diversity planning and practice to:

- improve the accessibility and responsiveness of services to people who are eligible for HACC services and are marginalised or disadvantaged due to their diversity
- improve the capacity of the service system to respond appropriately to their needs.

This approach aligns with person-centred care and an active service model approach.

Both share the common goal of responding to the specific characteristics and circumstances of the person seeking services.

What is diversity?

Diversity is a concept which recognises that each person is unique and has different beliefs, values, preferences and life experiences.

For some people these differences may result in barriers to accessing or using HACC services. Barriers such as a lack of confidence, a lack of information or a belief that a service will be unable to respond to their needs may impede a person's willingness or ability to access a service.

Diversity practice includes consideration of the HACC five special needs groups and the characteristics within and across these groups. Diversity 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).

By taking into account the diversity characteristics of individuals and communities, HACC services can better respond to the needs of individuals and communities.

It is also important to recognise that diversity is not a static concept. The characteristics and needs of each group or person may change over time. For example, population demographics may change or people may become more experienced and confident service users so they no longer require assistance in accessing services, or carer's needs or circumstances may change.

For further information see:

- Part 2: 'Eligibility and priority'
- Part 3: 'HACC access and support'.

Diversity planning and practice

Diversity planning and practice is underpinned by principles that seek to achieve:

- equitable access to HACC services by those eligible, regardless of their diversity or disadvantage
- a respectful and responsive approach to planning services that acknowledges the community, group or person's uniqueness and complexity of need
- consideration of diversity as core business, and as central to strategic planning and leadership.

Consideration of factors that influence a person's knowledge of and capacity to access services assists HACC service providers improve equity of access.

Diversity planning helps ensure that services adopt a 'diversity lens' when planning how to make services accessible and responsive for HACC-eligible people.

Diversity planning uses a population planning approach to:

- understand the characteristics of the HACC target population in a catchment area
- map the geographic distribution of groups of people who share these characteristics
- consider implications for how agencies deliver their services.

HACC funded organisations have developed diversity plans for the HACC triennium (1 July 2012 to 30 June 2015). The process of developing and documenting diversity plans required HACC funded organisations to:

- demonstrate an understanding of their catchment's HACC target population
- identify people and groups who may not be accessing services equitably
- provide opportunities for HACC-eligible people and other key stakeholders to inform this process
- set priorities in line with those identified in regional diversity plans
- develop an action plan that has achievable and measurable outcomes
- implement the plan
- monitor the plan against outcomes
- review the plan and use relevant information to develop the next plan.

Successful diversity planning and practice seeks to ensure that:

- appropriate organisational policies are in place
- a skilled and adequately resourced workforce is available to respond effectively to the needs of any person who is assessed as requiring a HACC service.

Organisations are not required to increase the number of people using services or provide extra service hours.

For a detailed guide to diversity planning and practice, information sources, practical strategies, case studies, examples and tools see *Strengthening diversity planning and practice: a guide for Victorian Home and Community Care services* (Department of Health 2011).

For further information see the *Service agreement information kit for funded organisations*:

- section 4.13: 'Language Services Policy'
- section 4.14: 'Cultural diversity guide'.

The 'Cultural diversity guide' includes the Victorian Government Aboriginal inclusion framework and *Enabling choice for Aboriginal people with a disability*.

Reporting requirements

HACC funded organisations are required to provide a progress update to their triennial diversity plan by 30 May of each year. This update can include amended priorities if required.

Links

Diversity planning and practice policy statement

http://www.health.vic.gov.au/hacc/downloads/diversity/diversity_policy.pdf

Strengthening diversity planning and practice: a guide for

Victorian Home and Community Care services (Department of Health 2011)

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

Service agreement information kit for funded organisations

www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement

Service coordination, assessment and care planning

Introduction

This section describes the requirements for HACC funded organisations to implement the four elements of service coordination.

These elements are:

- initial contact
- initial needs identification
- assessment
- care planning.

The department's service coordination policy is described in the *Better access to services framework*.

The *Victorian service coordination practice manual* (Department of Health 2011) and the Service Coordination Tool Templates (SCTT) provide standards of practice and a set of tools to support service coordination on a statewide basis. These resources are regularly reviewed and updated.

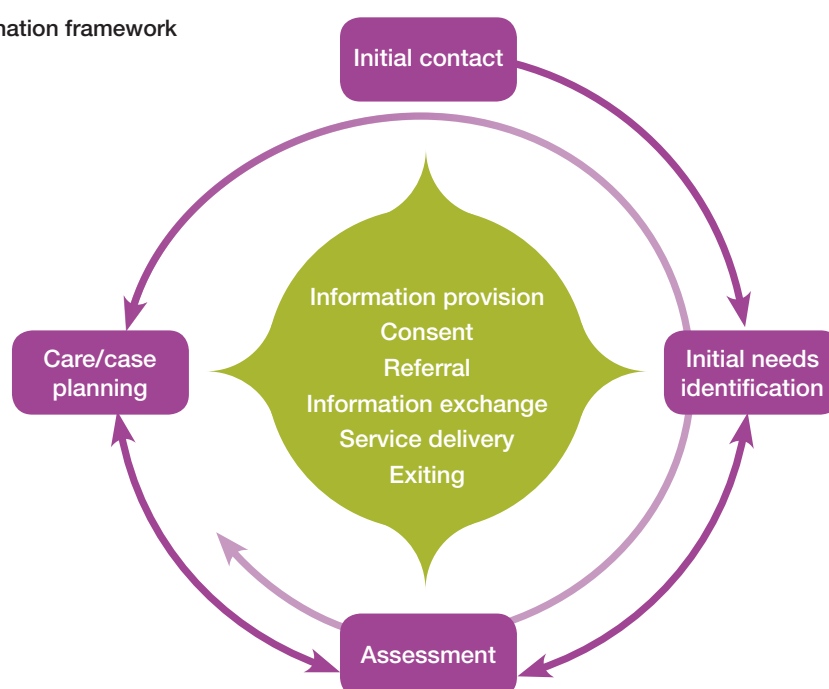
Service coordination

Service coordination is the process by which organisations work together in an integrated and coordinated way with the person at the centre of service delivery.

The HACC active service model is aligned with service coordination. Both approaches are person-centred, reflect a social model of health, and support a person's capacity to optimise their health and wellbeing.

The active service model focuses on restorative care and strategies to increase or maintain a person's ability to live independently in the community.

Figure 1: Service coordination framework



Initial contact and initial needs identification

Initial contact is a person's first contact with a HACC funded organisation, and in some instances the service system as a whole. During initial contact, basic client information is collected and information on service provision is provided.

Initial needs identification (INI) is a broad screening process to identify:

- whether a person is HACC eligible
- the needs and issues that underlie the person's needs
- opportunities for early intervention, health promotion and improved health and wellbeing
- level of priority.

Depending on the person's circumstances, INI covers broad areas of a person's life including: activities of daily living; carer needs, living arrangements; accommodation, cultural needs; and personal safety.

Information from the INI and the assessment process may result in referrals to other agencies if the person has broader needs that cannot be met by their organisation.

Agencies need to comply with the new Vulnerable People in Emergencies Policy and should include screening for assistance with personal emergency planning in their INI processes.

See section 4.18 of the *Service agreement information kit* for the Vulnerable People in Emergencies Policy.

Assessment

Assessment builds on the information collected at initial contact and initial needs identification.

Assessment is an ongoing process of building a rapport with a person and their carer. Assessment begins at the first contact and continues through to service delivery, review and reassessment as circumstances change.

A clear understanding of the different assessment pathways is important to ensure that:

- people are assessed by the right person at the right time
- people are assessed by staff with the appropriate expertise
- assessments build on each other but do not duplicate
- repetitive information gathering is minimised.

Pathways for assessment in the HACC program are described in section 1.2 of the *Framework for assessment in the HACC program in Victoria* (Department of Human Services 2007).

Service-specific assessments

Service-specific assessments focus on the person's needs for a particular type of HACC service. This includes clinical assessments for nursing and assessments for allied health interventions.

All HACC clients will receive a service-specific assessment.

The purpose of a service-specific assessment is to identify the person's needs in relation to a particular area for example, meals support, respite, domestic assistance, personal care or social support.

The outcome of a service-specific assessment is a care plan, sometimes called a service plan, which outlines the actions and interventions to be provided.

While assessments will be based on presenting and underlying needs and will therefore vary for each person, they all build on the INI process and include:

- the collection of information from the person and their carer about the person's strengths, what they can do for themselves, activities that the carer carries out and areas where assistance is needed
- a focus on the person's goals and priorities and how the HACC service can assist in improving the person's capacity to remain active and independent at home
- the person's diversity and cultural requirements relevant to the service to be provided, such as any personal care requirements
- identification of occupational health and safety issues
- risk management and fees assessment
- practical information, for example in relation to the preferred hours of service delivery, transport and fees.

Living at home assessment

There are 99 designated HACC assessment services in Victoria. HACC assessment services comprise 73 local governments, 16 community health centres and health services, and 10 nursing and NGOs.

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

- initial contact and initial needs identification
- a holistic needs assessment with the person, carer and family members, usually in their own home, which focuses on:
 - opportunities for improving functional capacity and participation in social and community activities
 - risk management
 - identification of occupational health and safety issues
- service-specific assessments for services provided by the assessing organisation (as required) including an occupational health and safety assessment (OHS)
- goal directed care planning and service-specific care plans (as required)
- care coordination for people receiving multiple services and/or services from multiple organisations.

People can self-refer to a HACC assessment service or referrals can be made by carers, family members or other service providers including hospitals and general practitioners.

Other HACC organisations should refer to their local HACC assessment service if they believe that a HACC-eligible person has broader needs that cannot be addressed through their organisation.

For further information see:

- *Service agreement information kit for funded organisations:*
 - section 4.13: 'Language Services Policy'
 - section 4.14: 'Cultural diversity guide'.

The 'Cultural diversity guide' includes the *Victorian Government Aboriginal inclusion framework* and *Enabling choice for Aboriginal people with a disability*.

Care planning

The purpose of care planning is to identify and design strategies to enhance a person's capacity for independent living.

Care planning should be guided by a person's goals, interests and aspirations and involve family members and carers.

It should build on the person's strengths and capacities, and consider opportunities for health promotion. Care planning aims to ensure individuals can remain active and connected to their community during and after service provision.

Care plans link the needs and problems identified at assessment to specific actions and interventions. A copy of the care plan should be provided to the person receiving care.

For some people, the assessment process will result in a relatively simple care plan, while for others care plans will be more complex and involve multiple strategies, interventions and agencies.

All HACC funded organisations should be working towards implementing goal directed care planning. Goal directed care plans detail:

- needs and goals to be achieved
- the nature of interventions or tasks to be performed by HACC-funded staff members as well as by the person themselves and/or carers and family members
- referral to a HACC assessment service or other agencies if broader needs are identified
- when and where HACC services will be provided
- the fee structure
- review dates and expected timeframe for service exit where applicable
- the occupational health and safety (OHS) plan.

Further information about assessment requirements of each HACC funded activity is contained in Part 3.

Care coordination

A subset of people with complex needs will receive services from multiple organisations and may require interagency care planning.

In these circumstances a care coordinator is nominated to develop a shared support plan and facilitate service reviews in accordance with the care plan.

A HACC provider may take on this role if:

- the client needs an interagency response and does not have a care coordinator from another program area such as Hospital Admission Risk Program (HARP)
- the HACC provider has the relevant expertise to carry out the care coordination role.

Care coordinators liaise with the person and other participants in their care, such as general practitioners, to develop, monitor and review the shared care plan.

The practices and standards described in the *Victorian service coordination practice manual* and the *SCTT shared support plan* should be used to support a coordinated approach.

Service Coordination Tool Templates

Service Coordination Tool Templates

The Service Coordination Tool Templates (SCTT) is a suite of templates developed to facilitate and support service coordination practice.

The SCTT is designed to record and share information as part of service coordination practice.

Use of the SCTT assists service providers and practitioners to:

- collect and share common consumer information
- consider information across a broad range of health and wellbeing domains in accordance with the social model of health
- record information in a uniform manner generated by initial contact, initial needs identification, assessment and care planning
- record consumer consent to share information
- make quality referrals and provide feedback
- develop and share care plans
- reduce the potential duplication of information and improve coordination if a person is receiving multiple services.

Use of the SCTT

The HACC program encourages the use of relevant SCTT tools as part of initial contact, initial needs identification and service coordination practice. The HACC program does **not** require every SCTT tool to be used for every client. Templates and profiles should be used as relevant to the person's individual needs and circumstances.

HACC funded organisations are **required** to use the relevant SCTT tools when making referrals to other HACC, health or community service organisations.

SCTT 2009 was reviewed and updated in 2012. The SCTT 2012 tools are available on the Primary Care Partnership website in PDF and interactive word format. The *SCTT user guide* (2012) is also available online.

The SCTT 2012 technical and functional specifications to support electronic data collection and referral are available to software vendors on the department's Primary Care Partnerships website.

Where organisations are using the SCTT in paper based form only they should be using the SCTT 2012 templates.

SCTT 2009

SCTT 2009 contains four core templates, six optional profiles, the Care Coordination Plan and two supplementary templates.

The minimum SCTT 2009 tools required for referral purposes are:

- consumer information
- summary and referral information
- consumer consent to share information (retained by the sender)
- living and caring arrangements.

Depending on whether the HACC organisation makes referrals electronically or by paper (such as fax) the *SCTT confidential referral cover sheet and acknowledgement* may also be required.

SCTT optional profiles are sent with a referral where relevant.

HACC assessment services, Linkages, nursing and allied health services should complete and send the *Functional assessment* summary when making referrals in order to streamline assessment processes and reduce duplication.

SCTT 2012

SCTT 2012 contains 15 templates.

- Core templates:
 - referral cover sheet and acknowledgement
 - consumer information
 - summary and referral information
 - consent to share information.
- Optional profiles:
 - single-page screener for health and social needs
 - need for assistance with activities of daily living
 - accommodation and safety arrangements
 - health and chronic conditions
 - social and emotional wellbeing
 - care relationship, family and social network
 - alcohol, smoking and substance involvement screening (ASSIST)
 - shared support plan.
- Supplementary templates:
 - information exchange summary
 - functional assessment summary
 - palliative care supplementary information.

Refer to the *SCTT user guide* (2012) for detailed information on each of these tools.

The minimum SCTT 2012 tools required for referral purposes are:

- referral cover sheet and acknowledgement
- consumer information
- summary and referral information
- consumer consent to share information (retained by the sender)
- accommodation and safety arrangements.

Further guidelines about the use of SCTT 2012 by HACC funded agencies will be developed in 2013. The *Functional Assessment Summary* must be used as per SCTT 2009.

Reporting requirements

HACC funded organisations are required to participate in the Department of Health, *Annual service coordination survey* as distributed through the department and Primary Care Partnerships.

Links

The Victorian service coordination practice manual, SCTT user guide 2012 and suite of SCTT tool templates <http://www.health.vic.gov.au/pcps/coordination/index.htm>

SCTT 2012 technical and functional specifications
http://www.health.vic.gov.au/pcps/coordination/info_management.htm

Framework for assessment in the HACC 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>

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

Carer Recognition Act (Commonwealth) 2010
http://www.fahcsia.gov.au/sites/default/files/documents/07_2012/carers_recognition_act_0.pdf

Vulnerable People in Emergencies Policy
<http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement/contents>

HACC assessment services in each local government area (Department of Health 2013)
http://www.health.vic.gov.au/hacc/downloads/pdf/assess_list_2013.pdf

HACC interface with other programs

Introduction

A HACC service may be one of several services a person receives in order to live at home as independently as possible.

HACC agencies need to know which government funded programs have specific arrangements in place with the HACC program and, what these arrangements or guidelines are.

This section describes the HACC program interfaces for these programs and services.

For a comprehensive listing of all funded services refer to the Human Services Directory (HSD). The HSD aims to provide practitioners and service providers with access to accurate and up-to-date information about health, social and disability services in Victoria.

Seniors Online Victoria is another comprehensive source of information.

Aged Care Assessment Program

The Aged Care Assessment Program is a national program jointly funded by the Commonwealth and Victorian governments. It is administered by the Victorian Department of Health under a cooperative arrangement with the Commonwealth Government.

The target group is frail older people over the age of 65 and Aboriginal people from age 50. Aged Care Assessment Services (ACAS) also assess younger people with a disability when other age-appropriate services are unavailable.

ACAS conduct comprehensive assessments to determine if a person needs community services or aged care residential services, and assesses for restorative care among other potential options.

ACAS determine whether a person is eligible to access:

- Commonwealth funded residential care
- Residential respite
- Home Care Packages
- Flexible care (Transition Care).

ACAS will accept referrals from any source, including frail older people and their families, general practitioners, hospitals and service providers.

Following the introduction of the Commonwealth Living Longer Living Better aged care reforms, there has been no change to processes for referrals from HACC to ACAS.

From August 1 2013 Home Care Packages are offered at four levels (levels 1–4). For the purposes of ACAS assessment the four packages have been 'broad banded' into two bands, the lower band being level 1 and 2 and the higher band being level 3 and 4.

People with a current CACPs approval can be offered a Level 1 or 2 package without another ACAS assessment.

People with a current EACH or EACHD can be offered a Level 3 or 4 package without another ACAS assessment. If no Level 3 or 4 packages are available they may be offered a level 1 or 2 package in the interim.

The *Guidelines for streamlining pathways between ACAS and HACC assessment services* (Department of Health 2011) describe the recommended referral pathways for frail older people to reduce unnecessary duplication of assessments.

The purpose of the guidelines are to:

- make sure that frail older people and their carers get the right assessment at the right time
- minimise the number of times frail older people and their carers have to tell their stories
- reduce waiting times for assessment.

Commonwealth funded aged care packages

The Commonwealth Government *Living Longer Living Better* aged care reforms commenced in August 2013.

Key measures include:

- Additional package care levels so there are now four package levels (levels 1 - 4) available.
- a new dementia supplement to provide additional financial assistance to people with dementia receiving any of the four levels of packaged care (10 per cent of the package value).

Commonwealth Home Care Packages

Four levels of Home Care packages have replaced the CACPs EACH and EACHD packages:

- Home Care Level 1 — for people with basic care needs
- Home Care Level 2 — for people with low-level care needs
- Home Care Level 3 — for people with intermediate care needs
- Home Care Level 4 — for people with high level care needs

A Dementia and Cognition Supplement of 10 per cent will be available at all four levels of home care for people assessed as having a cognitive impairment.

For more information about changes to Commonwealth aged care services go to the *Living Longer Living Better* website or *myagedcare* website.

Interface with HACC

General principles relating to access to HACC subsidised services for people in receipt of Commonwealth community aged care packages (CACPs) were developed by the department in 2010. These guidelines will be updated to reflect the new Commonwealth Home Care Packages guidelines.

In the meantime the following principles apply:

- As a general rule, people in receipt of a home care package are not eligible to receive the full range of HACC subsidised services. For example personal care, delivered meals, domestic assistance, respite and property maintenance can be provided through Commonwealth Home Care packages so they would generally not be provided to clients as a HACC subsidised service.
- Level 1 and 2 package clients can receive HACC subsidised nursing and allied health, as a HACC client.

- In Victoria, where a Level 1 and 2 package client was attending a planned activity group prior to going on the package, they can continue to do so as a HACC client in their own right. Similarly where a person is in receipt of a Level 1 and 2 package and not currently a member of a social support group, they can be considered for a HACC subsidised place as a HACC client in their own right.

Being eligible to be considered for a HACC subsidised place does not confer entitlement to service provision. Eligibility means that the person is in the HACC program's target group and is eligible to be assessed and prioritised for service provision. Services may not be able to be provided due to other people being assessed as a higher priority and/or due to resources not being available.

Commonwealth funded residential aged care

HACC funded services are not generally available to people living in residential aged care.

When a person using HACC services moves to residential care HACC services cease. This should be handled sensitively and allowances made for a transition period, for example, through attendance at a planned activity group.

HACC type services may be provided to residents in aged care facilities only:

- on a full cost-recovery basis
- where the HACC service provider has the capacity to service additional people without adversely affecting people in the HACC target group.

The Commonwealth reforms to residential aged care will be introduced in July 1 2014. See the Commonwealth Living Longer Living Better web site for information on residential aged care.

Compensation payments

Where a person has received a substantial lump sum compensation payment intended to cover the cost of care, fees for HACC services should be set at the full cost-recovery rate. If the lump sum is not substantial or a periodic payment has been granted, HACC program subsidies and fee reductions can be applied.

All clients should be assessed as to their ability to pay fees, including those who receive a lump sum or periodic compensation payment.

For further information see Part 1: 'Fees policy'.

Disability services

Disability services provides and funds services for people with a disability, and their families, to meet their disability related support needs.

Disability related support needs include assistance to maintain or increase independence and skills to participate in the local community.

People with a disability and their family or carers can request disability supports if:

- the person has a disability
- the disability impacts on mobility, communication, self-care or self-management
- the support request meets specific requirements related to the service being sought.

Disability supports may not always be suitable. For example, a person with a chronic health issue may have their needs better met through health services.

There is a high demand for disability supports and allocation is prioritised based on each person's circumstances. Requests for disability supports are considered along with all other requests. It is not possible to specify in advance when a support will become available.

Access to disability services

Ongoing supports such as Individual Support Packages (ISPs) and supported accommodation are accessed via the Disability Support Register (DSR).

The DSR is a database of all people who are requesting ongoing disability supports. The DSR enables the department to allocate supports in a fair and efficient manner when resources (funding or vacancies) become available.

People with a disability are eligible to access health services the same way as other members of the community. This includes people accessing individual support packages (ISPs) and people who live in disability-supported accommodation including group homes, congregate care or residential institutions.

Individual support packages (ISPs)

ISPs are an allocation of funding to a person with a disability to purchase supports that will best meet their disability related support needs.

Supports purchased with an ISP are not intended to replace those provided through informal sources or other community or government services. Ideally, an ISP will complement other community and informal supports.

ISPs are allocated in accordance with the *ISP guidelines* with particular reference to a set of funding principles. The funding principles state, among other things, that:

- ISP funding (funding) must be used to purchase supports that are directly related to the person's disability needs and to achieve the goals identified in their support plan
- funding is not provided as income for the person.

When a person is offered an ISP, they undertake a comprehensive planning process to determine:

- what supports they need
- who will provide the supports
- how ISP funds will be managed.

This information is included in a funding proposal that is submitted to the relevant departmental region for approval. Once approved, it becomes the person's funding plan and the person can implement the plan as required. The person may make changes during the life of their plan (usually three years) without seeking further regional approval, provided the changes remains consistent with both the goals of their funding plan and the funding principles.

People may be allocated an ISP based on a notional funding allocation determined at the time of DSR registration. Funding is allocated within four broad bands.

See the *Individual support package guidelines* (Department of Human Services, 2010) for more information.

Supported accommodation services

Long-term disability-supported accommodation may be requested for people who require rostered support. This service is targeted to people with a disability who have the highest support needs.

The majority of supported accommodation services in Victoria support five to six people living in a share house arrangement. Disability support workers support people living in supported accommodation in areas such as household management (for example cleaning and shopping) and general personal care (for example eating, bathing, dressing and preparing food).

Access to HACC services: HACC and ISP interface

Younger people with a disability may access HACC Linkages packages depending on their assessed need, priority and the package availability.

Younger people with a disability cannot access a Linkages package and an ISP at the same time. When a person applies to the Disability Support Register (DSR) for an ISP, ongoing disability supports including existing Linkages supports should be included in the application.

If a younger person has been allocated an ISP and is already using Linkages, the Linkages case manager in collaboration with the ISP facilitator can apply for an increased ISP to cover the cost of Linkages supports. The Linkages supports should continue until the additional ISP funding is approved.

People receiving an ISP are not automatically excluded from HACC services. If a person is receiving or has placed a request for an ISP, then the HACC provider should take this into account when reviewing the services they are providing. The decision to provide HACC services to someone on an ISP should be made on a case-by-case basis and will depend on the level of demand for services within each HACC organisation.

Interface with supported accommodation services

People who live in disability-supported accommodation including group homes, congregate care and people living in Colanda Residential Services (in Barwon South West region) are eligible for HACC funded nursing and allied health services to enhance independence and to reduce the risk of premature or inappropriate admission to residential aged care. Access to these services is based on priority of need as per all HACC clients (see Part 2: 'Eligibility and access').

Residents of disability-supported accommodation are expected to transfer to the National Disability Insurance Scheme (NDIS) launch operating in Barwon, from April 2014. Residents of Colanda Residential Services will transfer in September 2014. After they transfer, their on-going support needs will be met through the NDIS, to the extent that they are related to their disabilities.

People living in supported accommodation are not eligible for other HACC services such as delivered meals, domestic assistance, respite and personal care, insofar as services of this kind are expected to be supplied by the supported accommodation provider.

Housing

The HACC program supports people to live in their own homes, which include private rental dwellings, rooming houses, supported residential services, retirement villages, caravan parks and in some circumstances a state government funded residential service.

People in these tenures may be eligible to be assessed and prioritised for a HACC service, but a HACC service cannot be provided if there is a legislative or contractual requirement for the accommodation proprietor to provide that service. For example, a HACC service cannot provide a meal or cleaning service that is the responsibility of the owner of a supported residential service.

Private rental

A person renting a flat or house can be assessed and prioritised for all HACC activities with the exception of some property maintenance. A person in a rented flat or house can access limited property maintenance (with the approval of the landlord) for those costs that are normally the tenant's responsibility, for example installation of ramps and rails, or minor maintenance and repairs.

Rooming houses, private hotels and caravan parks

People living in insecure tenures such as rooming houses, private hotels and caravan parks, excluding recreational users, may experience barriers to access of HACC services. Diversity planning strategies and the use of outreach service models may be required for this group.

These residents usually pay only for accommodation, as per private rental, and are eligible to be assessed and prioritised for all HACC services including limited property maintenance. Property maintenance can be provided, with the permission of the owner, and may include the installation of ramps and rails in areas used by the person, or maintenance work in the resident's room. This maintenance can include a range of activities that are usually the responsibility of the tenant, for example changing light globes and maintenance and repair of the resident's furniture.

Retirement villages

Tenure and contract arrangements for retirement villages may vary widely. For example, in some villages the resident charge includes the provision of activities and transport. Each case needs to be considered and an understanding gained of what services the retirement village is required to provide before a HACC service can be provided.

Supported residential services

Supported residential services (SRSs) are premises where accommodation and special or personal support is provided for a fee. Special or personal support may encompass a range of services including assistance with personal hygiene and meals. SRSs are privately owned and operated but are regulated by the Victorian Department of Health.

SRS residents are potentially eligible for HACC services provided that the activity is not included in the resident's residential and services agreement (the agreement between the resident and the SRS proprietor).

Before assessing an SRS resident, HACC assessors should obtain a copy of the agreement. Relevant HACC services might include podiatry or other allied health services, nursing or planned activity groups.

In the pension-only SRS sector, a resident's entire income may be going towards accommodation and support costs. In these circumstances HACC fees may need to be waived.

Personal Alert Victoria

Personal Alert Victoria (PAV) is a daily monitoring and emergency response service funded by the Victorian Government through the Department of Health. The PAV program interfaces with the HACC program in two ways:

- HACC assessment services and community health services are designated PAV assessment agencies. PAV assessment is designed to be part of a broader assessment process, where the person is assessed in their home for a range of services, of which PAV may be one option.
- A response service which acts as the incident contact for people using PAV who do not have family or other contacts who can respond to an incident.

For further information refer to *Personal Alert Victoria guidelines*.

Veterans' Home Care program

The Department of Veterans' Affairs (DVA) Veterans' Home Care (VHC) program is designed to assist those veterans and war widows and widowers who wish to continue living at home and who need a small amount of practical help. Services may include domestic assistance, personal care, safety related home and garden maintenance, respite care and limited social assistance.

Interface with HACC

With regard to domestic assistance, personal care, safety related home and garden maintenance, and respite care, veterans can choose to receive either VHC services or HACC services, but cannot receive both.

Veterans who are receiving HACC services may choose to transfer to VHC or continue to receive HACC services.

Eligible veterans may access HACC planned activity groups and delivered meals. These are funded by DVA through the Victorian Department of Health, based on assessed and prioritised need and service availability. DVA contributes to the HACC program to facilitate veterans' access to these services. Providers are required to report on usage through the HACC minimum data set (MDS).

Continuing Care program

The Victorian Department of Health's Continuing Care Unit funds a range of clinical, community and home-based programs for people who:

- are at risk of hospital admission
- are experiencing chronic health issues or functional decline and require multidisciplinary interventions to assist them to live independently at home
- have experienced an inpatient episode of care and are eligible for services to support their care pathway to return home.

People using HACC who have had an inpatient admission may receive support from a Continuing Care program as part of their inpatient or post-acute care pathway.

These services are usually provided in the person's home, and include:

- Hospital in the Home (HITH)
- Post-acute care (PAC) services
- Transition Care Program (TCP).

In addition, there are continuing care services which HACC may refer to including:

- Hospital Admission Risk Program (HARP)
- palliative care
- Subacute ambulatory care services (SACS) comprising community rehabilitation services and a range of specialist clinics.

With the exception of SACS, these services provide home-based nursing and other HACC-like services. When this occurs it is important that the person experiences continuity of care and coordinated care.

Working together

The following principles should guide the integration and continuity of care when people are receiving both HACC and continuing care services at the same time or as linked episodes of care.

- The continuing care service provider and the HACC service provider should work collaboratively to develop the care plan and identify who will be the primary care coordinator during the episode of care.
- Wherever possible, the person's care provider should be continuous across these episodes of care. Who pays for that care and who delivers the care are issues that need to be clarified early in the discharge process to enable continuity of care. However there will be some circumstances in which HACC service providers will not be able to provide continuity of service because they are unable to provide services on a full cost-recovery basis.
- Based on a review by the HACC service provider, any pre-existing HACC services, such as domestic assistance, respite or delivered meals, should continue during the continuing care episode, such as PAC, HARP, HITH and palliative care.
- Nursing will usually be provided by the continuing care provider. The interface between each of the continuing care programs and HACC is described below.

Hospital in the Home

Hospital in the Home (HITH) is the provision of acute care to public hospital patients in the person's own home or other suitable environment. HITH provides an alternative to hospital admission or an opportunity for earlier relocation home. Many HITH patients are elderly and chronically ill.

Interface with HACC

When HITH and HACC are both providing care to a person, the HITH service is the primary care coordinator and will contact the HACC service provider to discuss the care plan. People receiving HACC services prior to a HITH episode should continue to receive the services at the same level (particularly for services like home help and meals) during their HITH episode.

The HITH service will provide all nursing care, regardless of whether HACC nursing has been provided prior to the HITH episode. However, on rare occasions HACC nursing may continue to be provided on HITH leave days if the process is coordinated and is in the best interests of the person.

Personal care needs will be assessed by the HITH program to ensure no additional risk is placed on existing HACC providers. If the person is at their usual level of acuity and function, existing HACC personal care can continue. However, if the person requires a greater level of assistance or staffing competence during the HITH episode, the HITH program should provide that care.

If the acute condition requiring HITH admission necessitates an increase in HACC services, HITH is responsible for planning, funding and monitoring the additional services. Where possible, the HITH service is encouraged to use providers that promote continuity of care.

Where no HACC support services have been in place HITH will arrange and fund the services required during the admitted episode and refer to HACC as appropriate for continuing care at the end of the HITH episode.

Post-acute care

Post-acute care (PAC) services support people discharged from a public hospital including emergency departments, acute services and subacute services, who have been assessed as requiring short-term, community based supports to complete their recuperation in the community when hospital services are no longer needed. PAC provides flexible in-home services to enact safe discharge.

Interface with HACC

For people using HACC services:

- PAC provides additional short-term support relevant to the inpatient episode. Prior to the person's discharge, PAC and HACC providers need to plan for and determine the continuity of care arrangements.
- Pre-existing HACC services that are not impacted by the hospital episode, for example delivered meals or domestic assistance, should resume as soon as possible once the person returns home. HACC needs to prioritise these clients for service resumption.
- HACC service providers may need to reassess the person's need for services such as personal care prior to the end of the PAC episode to determine ongoing needs.

For people not receiving HACC services prior to the hospital episode:

- PAC provides short-term care in the home where there is an assessed need for the person to complete their recuperation at home. HACC service providers need to assess the person prior to the end of the PAC episode to determine any ongoing need for services.
- Where there is a HACC need identified that is not related to the hospital episode, HACC needs to assess the person's needs as soon as possible post discharge.
- Where there is an unavoidable delay in HACC being able to provide services, PAC may provide services immediately post discharge until HACC can commence provision of the needed services.

Transition Care Program

The Transition Care Program (TCP) is funded jointly by the Commonwealth and Victorian governments. It aims to minimise the number of older people experiencing inappropriate extended hospital lengths of stay or being prematurely admitted to residential care. The *Transition Care Program guidelines 2011* (Department of Health) govern the provision and operation of the program.

Aged Care Assessment Services (ACAS) determine initial TCP eligibility. The TCP provides short-term support and active management for older people at the interface of the acute/subacute and community/residential aged care sectors. TCP can be provided as a bed-based service, either in low or high-level residential aged care or as a home-based service.

By offering case management, low-intensity therapy and personal support, the program allows older people more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and finalise and access long-term care arrangements.

Interface with HACC

TCP staff work closely with a range of community and residential service providers including HACC, to ensure timely referral, assessment and access to support during and after the TCP episode of care. It is likely that some people receiving the TCP will already be using HACC services.

In such instances, the TCP case manager will liaise with the HACC service provider to negotiate whether the HACC service continues, including consideration of continuity of care, or is suspended during the TCP episode of care.

Where there is no service agreement between TCP and the HACC service provider, an alternative service is utilised. Where there is agreement for the HACC service to continue, the TCP case manager will advise the HACC provider on the invoicing process.

The duration of the TCP episode will be determined by the person's goals at TCP admission, so the length of stay will not necessarily be 12 weeks.

For services required beyond the TCP episode of care, TCP will refer to HACC as soon as it is evident that a particular service is necessary to support an ongoing care need. Information will include notification of the expected TCP discharge date. A TCP extension cannot be granted on the basis of a service not being available, so it is essential that good communication and planning facilitate timely referrals, assessment and transition between TCP and HACC.

In TCP the cost for HACC-delivered meals and home modifications is borne by the person, at the HACC-subsidised rate, unless otherwise advised by the TCP.

Hospital Admission Risk Program

The Hospital Admission Risk Program (HARP) prevents readmissions to emergency departments and acute hospital settings by using evidence-based approaches delivered in a community or ambulatory setting including:

- care coordination
- access to specialist medical care
- self-management support
- complex psychosocial issues management.

HARP targets people who present frequently to hospital or are at imminent risk of doing so, and who have complex needs related to chronic disease or psychosocial factors, and where intensive care coordination and specialist care are required in addition to usual care.

HARP works across the hospital and community interface and links people into appropriate hospital or out of hospital care pathways.

HARP services have access to hospital systems that enable early recognition and prompt referral and links either into appropriate hospital or out of hospital care pathways. HARP is governed by the *Health independence program guidelines*.

Interface with HACC

HARP care coordinators work closely with specialist, subacute and community services to address immediate short-term needs, and to develop an integrated multi-organisation plan for ongoing care in the community setting. People receiving HACC services prior to a HARP episode should continue to receive the HACC services at the same level.

HARP may augment these services in the short-term, particularly with specialist medical or allied health assessment and intervention. HACC agencies refer to and receive referrals from HARP organisations.

Palliative care

The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care in Victoria is delivered in a number of settings, from people's homes with primary health and general practitioner support, through to acute health services and highly specialised settings. Palliative care is flexible to meet the needs of the person and their family.

Referral to palliative care services can be made by clinicians including general practitioners, acute health professionals, community health services, HACC services, aged care services and so forth, or by self-referral.

Interface with HACC

Collaboration in assessment and care planning between the HACC service provider and the palliative care provider is considered best practice. A collaborative approach allows both services to benefit from the other's skill and knowledge.

HACC services should continue when the person is referred to palliative care.

Pre-existing HACC services should be reviewed and a coordinated care plan developed with the palliative care service in order to provide the most appropriate support to the person and their family.

HACC and palliative care providers need to discuss the person's future care needs, possible transition to more intensive levels of care and make the appropriate referrals. A referral to ACAS may be required.

HACC funded nursing should continue on the basis of the nursing need relating to a pre-existing health condition. In some cases, HACC services may provide generalist nursing and the palliative care service may provide concurrent specialist palliative care nursing as well as other specialist palliative care.

Some people requiring palliative care services may not already be receiving support from the HACC program. In these instances palliative care should refer to or contact the local HACC assessment service to discuss the person's circumstances and determine the most appropriate assessment and/or care pathway.

Links

Victorian health and aged care services links

Health independence programs guidelines (Department of Human Services 2008)
<http://health.vic.gov.au/subacute/hip-manual08.pdf>

The Human Services Directory: <http://humanservicesdirectory.vic.gov.au/>

Personal Alert Victoria guidelines: <http://www.health.vic.gov.au/agedcare/policy/pav.htm>

Palliative care services in Victoria: www.health.vic.gov.au/palliativecare

Commonwealth funded aged care

Aged care review measures
<http://www.health.gov.au/internet/main/publishing.nsf/Content/aged-aged-care-review-measures-techdoc>

Commonwealth Home care packages information and guidelines: www.livinglongerlivingbetter.gov.au/myagedcare: <http://www.myagedcare.gov.au/>

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

Residential aged care
<http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Residential-care>

Seniors Online Victoria: <http://www.seniorsonline.vic.gov.au/Home.aspx>

Disability services links

Centre for Developmental Disability Health Victoria: <http://www.cddh.monash.org>

More information about disability services:
<http://www.dhs.vic.gov.au/for-individuals/disability>

Veterans home care links

Veterans' Home Care program:
http://www.dva.gov.au/benefitsAndServices/home_services/vetshomecare/Pages/

Victorian HACCC program manual

Part 3: HACCC 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 *Guidelines 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 HACCC 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

HACCC 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 HACCC 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 HACCC 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 HACCC 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
 - HLTF301B Apply first aid — with updates in accordance with the Australian Resuscitation Council Guidelines; or
- CHC08 Community Services Training Package Version 4
 - HLTF311A 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 HACCC 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 HACCC assistance with oral hygiene as long as this is done in accordance with the HACCC 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 HACCC 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 HACCC 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 HACCC assessment service. To aid this process, the HACCC 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.

HACCC 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 HACCC 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 HACCC 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 HACCC 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 HACCC program manual*. This contract should include procedures regarding communication, comment from the people receiving the meals and menu planning.

Food safety requirements for HACCC 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. HACCC 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 HACCC minimum data set (MDS).

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

The HACCC 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/\\$FILE/84-10082a080.pdf](http://www.legislation.vic.gov.au/domino/Web_notes/LDMS/LTObject_Store/LTObjSt2.nsf/d1a8d8a9bed958efca25761600042ef5/d104b68ff611fe30ca257761001fc67a/$FILE/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 HLTF207C Follow basic food safety practices. This is available as an online unit through the HACCC Education and Training provider.

Personal care

Where a person attending a planned activity group requires personal care, including assistance or monitoring of medication, the HACCC 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.

HACCC 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.

