Pennwood Home Care
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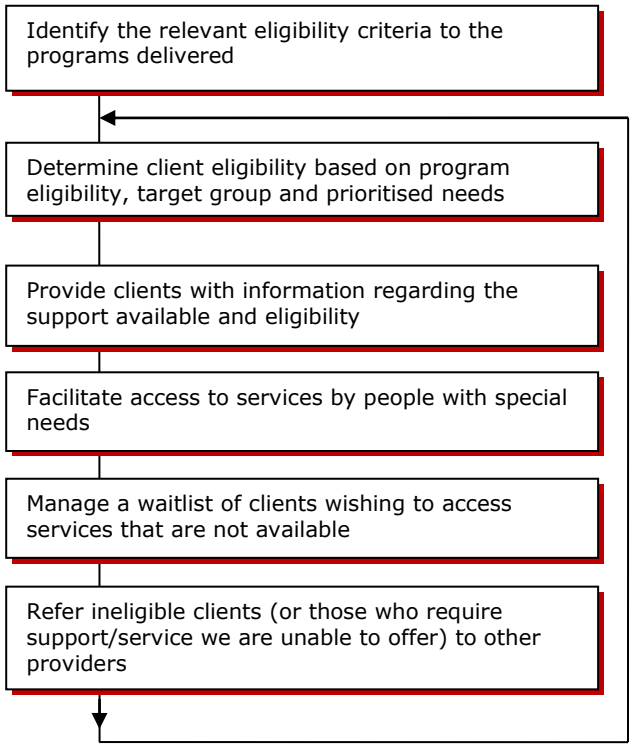
HC9 - SERVICE ACCESS

Pennwood Home Care ensures that each client's access to services is based on consultation with the client (and/or their representative), equity, consideration of available resources and program eligibility.



FORMS AND RECORDS

HS06 Home Safety Check	Client files
HS46 Deciding Priorities for Assistance	Client files
HS45 Deciding Priorities for Respite Care	Client files
Client records	Client Management System and client files
Client Spreadsheet	Shared Drive

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HC9.1 Accessing Services

Clients are referred by the assessing agency, ACAT, their doctor, other health professionals, family members or people in the community. Clients can also self-refer. A priority is given to those people most in need (see 9.2.2: Prioritising Need). Referrals are received by telephone, fax and email or face-to-face.

Clients and carers are not excluded from access to the service on the grounds of their gender, marital status, religious or cultural beliefs, political affiliation, particular disability, ethnic background, age, sexual preference, inability to pay, geographical location or circumstances of the carer.

9.1.1 CLIENT INVOLVEMENT

Clients (and/or their representatives) are consulted about the services that they identify as requiring. Eligibility is determined in the first instance and then further discussions are held with the Home Care Co-ordinator regarding the assessed needs and the services required.

Consumer Directed Care[1]

Clients who are provided support through a Home Care Package are supported to receive their package on a Consumer Directed Care (CDC) basis. The following describes our approach to the provision of CDC packages:

> *The User Rights Principles 2014 and the Charter of care recipient's rights and responsibilities-homecare (the Charter), which recognise the rights and responsibilities of consumers and providers, explicitly acknowledge the key elements of CDC, emphasising the right of consumers to exercise choices in relation to the care provided to them.*
>
> ***Choice and flexibility***
> *The Charter specifies consumers' right to:*
> - *be supported by the provider to set goals, determine the level of ongoing involvement that they wish to have, and make decisions relating to their own care and to maintain their independence as far as possible;*
> - *choose the care and services that best meet their goals, preferences and assessed needs, within the limits of the resources available;*
> - *have choice and flexibility in the way the care and services are provided at home;*
> - *participate in making decisions that affect them; and*
> - *have their representative participate in decisions relating to their care.*

[1] Department of Social Services – Home Care Operational Manual – September 2015

Care and services

Consumers have the right to:

- *receive care and services which are appropriate to meeting their goals, preferences and assessed needs;*
- *be given a written plan of the care and services that they expect to receive;*
- *receive care and services that take into account their preferences; and*
- *ongoing review of the care and services they receive, as required.*

Consumer Directed Care Principles

The following principles apply in our delivery of CDC packages:

- Consumer choice and control
- Rights
- Respectful and balanced partnerships
- Participation
- Wellness and re-ablement and
- Transparency.

9.1.2 REFERRALS TO OTHER AGENCIES

All services for clients are reviewed and monitored on an ongoing basis to ensure they are appropriate and effective. Where necessary, clients are referred to the Assessing Agency or other providers. This process is described in Section 13: Client Referral.

9.1.3 SAFE ENVIRONMENT

The organisation and staff of Pennwood Home Care ensure that all services are provided in a safe environment in line with Work Health and Safety requirements and our duty of care to clients, staff and volunteers. Sometimes in the client's home this is difficult to achieve. In these cases staff are made aware of the need to ensure the safety of the client and themselves.

The Home Care Co-ordinator completes a HS06 Home Safety Check at the client's home at their first meeting. In addition, staff have access to a HS48 Adverse Event Report (special incidents) to record accidents or incidents to the Home Care Co-ordinator. Staff complete a HS37 Hazard / Incident Form to record health and safety hazards in client's homes, which are then actioned by the Home Care Co-ordinator.

Should an unsafe environment be evident, staff contact their supervisor for advice and assistance and should endeavour to control the risk until further action can be taken.

See also 5.2 Continuous Improvement Forms for details on processing the forms. (Focus Groups)

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HC9.2 Eligibility and Access to Services

9.2.1 SUMMARY OF ELIGIBILTY CRITERIA FOR FUNDED PROGRAMS

Pennwood Home Care West provides services to clients and carers which are funded by the Government's Home Care Package Program. Clients must live in the Western suburbs of Adelaide. More detailed information regarding the service delivery expectations is included in 11.4 Range of Services Provided by Home Care Packages.

The following eligibility criteria apply:

Home Care Packages[2]

A person seeking information on Commonwealth funded aged care services can contact My Aged Care. If their care needs indicate that they may need a home care package, My Aged Care will refer them for an assessment to determine their eligibility.
An ACAT (or ACAS) is able to assess and approve a person's eligibility to receive Government subsidised care such as residential aged care, residential respite care, home care and transition care.

9.2.2 PRIORITISING NEED

When deciding priorities for clients the following are considered and a HS46 Deciding Priorities for Assistance form completed and filed in the client's records:

- Does the home appear environmentally unsafe?
- Is family support at risk of breaking down?
- Does the client need ongoing medical or nursing help?
- Does the client live alone, or with a carer who is also frail aged or has a disability?
- Does the client experience difficulty with a range of daily living tasks?
- Is the client geographically isolated?
- Is the client socially isolated?
- Does the client express financial disadvantage?

When deciding priorities for respite care (or carers needs) the following are considered a HS45 Deciding Priorities for Respite Care form completed and filed in the client's records:

- Is the carer caring for a person with a disability?

[2] Department of Social Services, July 2014 *Home Care Packages Program Guidelines p17*

- Is the carer a sole carer, has poor support networks or has dependent children?
- Is the carer frail, ill, stressed or has a disability?
- Does the carer have extensive commitments which may stop them providing care?
- Is the carer socially or geographically isolated?
- Does the carer express financial disadvantage?

9.2.3 ASSESSING ELIGIBILITY

Once a referral is received () an eligibility screen is completed by telephone, to ensure that the client lives in the allocated region and to ascertain if the provider has appropriate and sufficient resources to delivery the relevant services. If the client is eligible, an arrangement is made for the Home Care Co-ordinator to meet the client.

Packaged care clients all require an assessment by the Aged Care Assessment Team (ACAT) that determines their eligibility.

This process is further described in Section 10: Assessment.

9.2.4 RECORDING CLIENT WAITLIST AND REFUSALS

A waiting list is maintained in eTools and on the My Aged Care Portal. Potential clients are contacted and asked if they would like to be placed on the waiting list. If this request is declined the person is removed from the waitlist.

The Home Care Co-ordinator and Support Officer are responsible for maintaining both waiting lists.

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HC9.3 Clients with Special Needs

A full list of definitions of special needs is included in Section 4 Community Understanding and Engagement 4.2 Clients with Special Needs.

9.3.1 ABORIGINAL AND TORRES STRAIT ISLANDER CLIENTS

Our organisation endeavours to provide Aboriginal and Torres Strait Islander clients with culturally appropriate services, and where possible, services delivered by Aboriginal and/or Torres Strait Islander staff. The Home Care Co-ordinator, RN or EN ensures that the information regarding the assessment, review, service plan and services is clearly explained and understood by the client and their family.

9.3.2 PEOPLE WHO DO NOT SPEAK ENGLISH

If a person does not speak English an interpreter is used. If the person has a family member with them, they are used as the interpreter if this is acceptable to the client. Other options for interpreter services include a staff person or the Telephone Interpreter Service. We regularly provide support to Serbian and other Eastern European clients and try to provide them with information relating to advocacy and complaints their requested language.

9.3.3 CLIENTS WHO DO NOT READ OR WRITE

In cases where the client does not read or write, the Home Care Co-ordinator, RN or EN makes sure that the information in the Client Handbook, and information regarding the assessment, reviews, service plans and services is clearly explained and understood by the client and/or their carer.

9.3.4 CLIENTS WITH DEMENTIA AND OTHER SPECIAL NEEDS GROUPS

When necessary, the Home Care Co-ordinator, RN or EN identifies the need for support for clients with dementia or other special needs groups, such as those with disability or specific care needs. We provide training for relevant staff in how to work with people with dementia or people with disability or specific care needs. Our organisation makes every effort to make sure that services are delivered in an appropriate and sensitive way to all people, and in particular, to people with dementia and other special needs.

Referral to Social Worker and Counsellors must be made by the Home Care Co-ordinator.

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HC9.4 Team Communication

9.4.1 TEAM MEETINGS

The all home care staff meet monthly to discuss client needs and also have ad hoc discussions regarding clients as required. Meetings are minuted and provide staff with an opportunity to discuss new clients, care delivery, clients changing needs and provide staff development.

9.4.2 CASE CLOSURE

Clients may choose to cease being provided with services or may need referring to another provider if needs change or if we are unable to provide services.

If a client chooses to cease service delivery or we are unable to deliver services the Home Care Co-ordinator ensures that:

- Clients and their representative/s are assisted to seek other care options (if appropriate)
- Clients are provided with counselling and support during the transition
- Consultation and liaison occurs with the Home Care Co-ordinator, RN or EN
- Actions are taken to assist the client are documented in their client records.

9.4.3 CLIENTS WHO DO NOT RESPOND TO A SCHEDULED VISIT

See 11.2.4: Action in the Event of a Client not Responding to a Scheduled Visit.

HC9.5 Termination, Withdrawal or Change of Services – General Guidelines

(See 9.6 Security of Tenure for Home Care Packages for information specific to Home Care Packages).

Services may be terminated, withdrawn or changed in the following circumstances:

- Work, health and safety risk to staff/volunteers that can't be rectified
- Inappropriate client behaviour
- Change in client circumstances that influence eligibility
- The agency ceases to deliver the service.

Each of these circumstances is discussed in detail below.

9.5.1 WORK HEALTH AND SAFETY RISK TO STAFF/VOLUNTEERS

A Work Health and Safety risk can arise from a variety of factors including dangerous access to a person's house or dangers inside the house or home environment. These are identified through a HS06 Home Safety Checklist which is completed at the first visit for services, when reviews are carried out or when staff report a danger to their supervisor. Examples of these WHS risk issues could include:

- Dangerous steps, verandahs, internal flooring
- Faulty electrical wiring
- Dangerous roofs/ceilings
- Dangerous dogs
- Smoking in the immediate vicinity of staff.

Where a WHS risk is identified the Home Care Co-ordinator works with the client to remove or reduce the risk to an acceptable level. If this cannot be achieved through reasonable means the Coordinator can decide to cease the provision of services to the client where staff are at risk. All consultation, discussions and actions are documented in the client record.

9.5.2 INAPPROPRIATE CLIENT BEHAVIOUR

Inappropriate client behaviour includes any behaviour that causes staff to feel that their safety is threatened. This can include direct physical actions or threats, sexual suggestions, wilful exposure and foul language.

If inappropriate client behaviour occurs staff immediately leave the client's home and report the behaviour to the Coordinator verbally and complete an HS48 Adverse Event Report.

The Home Care Staff and Coordinator assess the client behaviour. If it is found inappropriate the Coordinator discusses this with the client and attempt to find a solution to ensure it does not occur again.

If inappropriate client behaviour continues after reasonable attempts to curb it the Coordinator can decide to cease the provision of services affected by the client's behaviour.

9.5.3 CHANGE IN CLIENT CIRCUMSTANCES THAT INFLUENCE ELIGIBILITY

Where client's circumstances or condition changes to the point that services are no longer required the Coordinator can decide to change or cease the provision of services to the client.

For example, if a person receiving meals and transport due to hip problems has a hip replacement and regains full mobility they may no longer need the service. Where a person's general well-being increases to a point where they can undertake all acts of daily living independently their services may be withdrawn.

Any changes required are discussed fully with the client, and their carer if appropriate, and are fully documented on the assessment form and in the client record.

9.5.4 THE AGENCY CEASES TO DELIVER SERVICES

If our organisation ceases to deliver services, clients are given maximum notice that the services are ceasing and they are provided with support to access other services, including referral processes.

9.5.5 PROCESS FOR TERMINATION, WITHDRAWAL OR CHANGE OF SERVICES

If support to a client is to be terminated, withdrawn or changed the following process applies:

1. Give the client as much notice as possible with a minimum of 1 (one) month

2. Explain face to face to the client, and their carer/family if appropriate, why the services are being ceased or changed and any arrangements required for the client

3. Provide written notice if appropriate

4. Attempt to find another agency to provide the required service and try to ensure services are provided without any break

5. If no other agencies are available identify other options in consultation with the client

6. Advise the client that they can appeal to the Coordinator, the decision to terminate, withdraw or change their services

7. Assist the client in appealing if necessary

8. Record all relevant information in the client records.

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HC9.6 Security of Tenure for Home Care Packages

We ensure the security of tenure of clients receiving Home Care Packages by advising clients when they commence on a package that, at some time in the future, they may not be able to continue on a home care package.

We will only reallocate a client's home care package to another person if[3]:

- the consumer cannot be cared for in the community with the resources22 available to the home care provider;
- the consumer tells the home care provider, in writing, that they wish to move to a location where home care is not available through the home care provider;
- the consumer tells the home care provider, in writing, that they no longer wish to receive the care; or
- the consumer's condition changes so that:
  - they no longer need home care; or
  - the consumer's needs, as assessed by the ACAT, can be more appropriately met by other types of services or care.
- the consumer does not meet his/her responsibilities, as described in the 'Charter of Care Recipients' Rights and Responsibilities – Home Care', for a reason within the consumer's control, for example:
  - if a consumer does not pay the fees or negotiate an alternative with their provider, the provider may re-allocate the consumer's package to another person.

If a transfer to another type of care is necessary, the home care provider should work with the consumer and alternative providers to ensure a smooth transition. This may include arranging another ACAT assessment.

If a client is changing location, their home care package is not automatically transferred; the client will need to be offered a home care package from another provider. We ensure continuity of service delivery during the transfer and assist where possible to arrange services in the clients' new location.

9.6.1 LEAVE PROVISIONS FOR HOME CARE PACKAGES

Clients can take leave from their package (as long as they advise us in writing) for a holiday, a hospital stay, transition care or respite care. The following arrangements apply for all home care packages[4]

[3] Department of Social Services - July 2014 *Home Care Packages Program Guidelines*

[4] Department of Health and Ageing August 2013 *Home Care Packages Program Guidelines*

Type of leave	**Impact on payment of subsidy to approved provider**
Hospital	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 *consecutive* days in a financial year, for each episode of hospitalisation. • After 28 consecutive days, the subsidy is payable at 25% of the basic subsidy rate.
Transition care	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 *consecutive* days in a financial year, for each episode of transition care. • After 28 consecutive days, the subsidy is payable at 25% of the basic subsidy rate.
Respite care	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 *cumulative* days in a financial year. • After 28 cumulative days, the subsidy is payable at 25% of the basic subsidy rate.
Social leave	• Home care subsidy is payable (at the full basic subsidy rate) for up to 28 *cumulative* days in a financial year. • After 28 cumulative days, the subsidy is payable at 25% of the basic subsidy rate.

Clients must continue to pay the ongoing care fee whilst on leave from their package except if they are in transition care or residential respite care.

HC9.7 Service Continuity

Our organisation complies with the Department of Social Services - Home Care Package Programme Guidelines – July 2014 and the Community Care Common Standards that relate to ensuring continuity of service.

HC9.8 Monitoring Service Access Processes

Service access processes and systems are regularly audited as part of our audit program and staff, clients and other stakeholders are encouraged to provide ongoing feedback on issues and areas where improvements can be made (see Community Calendar and Section 5: Continuous Improvement).