Case Management Practice Guide

7 Phases of Case Management

Version 2.0

Community Access
Ageing, Disability and Home Care, Department of Human Services NSW
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Document approval

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Table of contents

1 Introduction

The Practice Guide

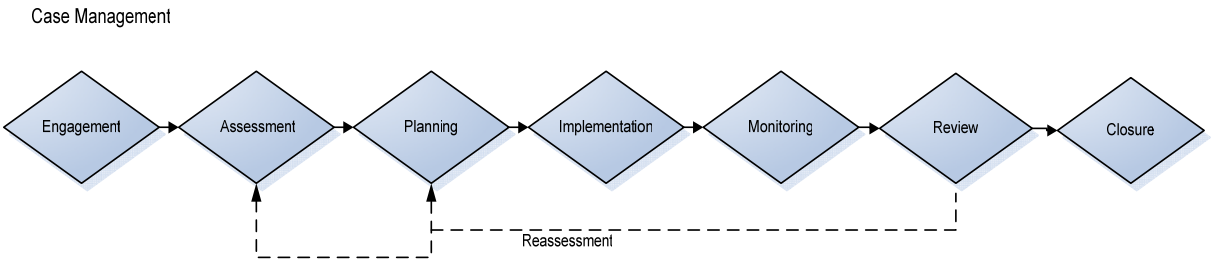
This practice guide is a companion document to the Case Management Practice Policy 2009 and is designed to support and guide case managers working in Community Access Teams in their every day practice. The guide is based on the 7 phases of case management practice as outlined in the Case Management Framework. This practice guide is not prescriptive but provides endorsed examples of practice points and tools for case managers to assist them to implement the Case Management Policy 2009.

Case management practice can be brief and intense but can also be delivered over a long period. Regardless of its duration, case management practice should move through all seven phases, although sometimes phases will happen simultaneously.

This practice guide should be used in conjunction with a range of policies and procedures relevant to case managers. Its application in practice should be supported through line management and practice supervision from your access manager and any coaching or mentoring you may receive in your role as case manager within Ageing, Disability and Home Care, Department of Human Services NSW (ADHC).

The 7 Phases of Case Management

The 7 phases of case management are:



Case management practice in all phases should be based on the principles outlined in the Case Management Practice Policy 2009. It is important to note that whilst it is useful to describe the activities of case management by categorisation into seven distinct phases, case managers need to be aware that case management is not a linear process and activities and phases often overlap. Case management should be a seamless process for people with a disability.

ADHC promotes a person centred approach to all its work with people with disability and their families and / or carers. Case management practice will have a different emphasis and focus in circumstances where the person with a disability is a child. A family centred approach will be critical in understanding the needs of a child or young person. Refer to Keeping Families Together Framework for further information.

Case Management Practice Outcomes

The expected outcome of case management practice is "*to maximise opportunities for a person with a disability to achieve their goals, and chosen quality of life*" (Case Management Practice Policy 1.6). This is achieved by individualised planning and support coordination. One of the key principles of case management practice is *"to minimise the intrusiveness and involvement of formal support services in the life of a person with a disability*" and "*to work with person with a disability to create opportunities for their*

participation in their community which are rewarding, respectful and valued by the person with a disability and other community members" *"* (Case Management Practice Policy, 2.2)

Working with Others

Case management in ADHC is not offered in isolation from other supports that the person with a disability may be receiving. Case managers will work alongside staff from many disciplines, agencies and organisations. This may include therapists, respite coordinators and people who provide the informal supports to the person with a disability. Whilst it is important to build collaborative relationships with all stakeholders involved, it is essential that these relationships maximise participation of the person with a disability. Conversations need to be with the person rather than about the person to reflect a person centred approach.

Information Exchange

Information shared with others needs to be accurate, relevant and with the explicit consent of the person with disability or their consent giver. Consent for the disclosure, gathering or exchange of information must be obtained in writing. The full policy is available at Decision Making and Consent Policy and Procedures.

Children and young people

Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (The Act) helps clear the way for better interagency information exchange provisions. Government and non-government agencies (known as "prescribed bodies") can exchange information with each other that relates to a child or young person's safety, welfare or wellbeing, whether or not the child or young person is known to Community Services. As per section 245G of the Act, a person who provides information in good faith in accordance with Chapter 16A, will not be liable for providing this information

ADHC is a prescribed body under Chapter 16A, which means that it can request and provide information to other prescribed bodies under Chapter 16A without the need for the consent of the child, young person or family. However, it is best practice for ADHC staff to inform a child, young person or their family that information about them may be provided to another organisation if needed, but only if:

- it will not jeopardise a child/young person's safety, welfare or wellbeing
- it will not place the worker or child/young person at risk, and/or
- you are unable to contact a parent/carer, and the matter is urgent.

A fact sheet on information exchange has been developed for ADHC staff in relation to information exchange. Further information regarding information exchange can also be found in ADHC's Child Protection Policy 2010.

Although Chapter 16A applies to the exchange of information between prescribed bodies, section 248 will still apply to the exchange of information concerning statutory cases between Community Services and other relevant human services and justice agencies and non-government organisations.

Reflective Practice

Reflective practice is a process where the individual thinks through a series of actions or activities to identify positive and negative elements contributing to any situation in which they have been involved or have observed. These elements can include, but are not confined to, the following:

- Relationships

- Feelings
- Experiences
- Events
- Context
- Actions
- Values and belief system
- Culture

The process can have two key components:

- Reflecting on the knowledge you have about people and events or outcomes.
- Using the knowledge to inform subsequent thinking, actions and practice.

Reflective practice is a critical component of good case management practice and can occur in a range of situations including individual problem solving and analysis, informal discussions with others such as colleagues, students, and academics in the same and different disciplines. It is an integral part of good supervision in which joint exploration of some of the issues arising in practice should be encouraged in an environment of safety and shared learning.

It is in conversation with others that ideas are challenged, new approaches and perspectives can be considered, and notions of what is possible and what is 'good practice' are developed and shared.

The process involves problem solving from a point of having knowledge and understanding about something and applying analysis to this knowledge to inform future thinking and actions. It is an ongoing process in which an individual case manager can draw on both the current situation and previous experiences to explore possible future action and consider the relative merits of any particular approach.

2 Phases of Case Management

2.1 Engagement

Successful engagement is the basis of effective case management. Engagement establishes the relationship and sets the ground rules which are enhanced and reviewed throughout the phases of case management. Engagement begins prior to the initial contact between the ADHC case manager and the person with a disability and their family and/or carer.

Engagement and relationship building involves meeting with and getting to know people with a disability and their circle of support. It is important that the case management relationship does not replace the natural supports of the person with a disability. Rather, practice is to support the person with a disability to enhance and strengthen these supports. Practice should build on a person's skills, abilities and strengths and support them to achieve what is important to them. To find out what these skills and strengths are, what their visions and hopes are, you must build a positive relationship with the person and their family and/or carer.

Engagement is about building a case management relationship marked by:

- Case managers ensuring they have good knowledge of disability and the service system.
- Good level of rapport between the case manager and the person with a disability and their supports.
- Knowledge and understanding of the expectations and experiences of the person with a disability, their family and/or carers in relation to the Agency and your role.
- Clarity about the case management purpose, focus and approach.
- Understanding of the functions and limitations of the case manager role.
- Honesty and trust in information exchange and decision making.
- Partnership of two way communication and mutuality in setting and pursuing goals.

Engagement is necessary for accurate and comprehensive assessment of the needs of a person with a disability and their family to identify their strengths, aspirations and priorities, and promotes active involvement and motivation to implement a plan. Successful engagement is essential in short or long term relationships, in a crisis situation or in a longer lasting relationship.

When you meet someone for the first time, you need to be clear about your role and you need to explain this role to each person. You are meeting someone as a case manager employed within the NSW Public Service and this role brings responsibilities of working within the Agency's policy and processes. You may use advocacy skills in your case management practice, but as a public servant you cannot fulfil the role of an independent advocate. Many people with disabilities may seek support from you as well as support from an independent advocacy service. Part of your role may be to help a person with a disability and their family locate and engage with an independent advocacy service.

Establishing rapport and building trusting relationships improves the likelihood of effective communication and facilitates information sharing. Communication may take a range of formats tailored to an individual. To understand the most effective means of communication, it is beneficial to involve a range of people from the person's formal and informal supports. In some situations extended family members and/or friends may be very involved with the person with a disability and should be factored into consideration of informal and family supports.

Time must be allowed to support the person with a disability to engage in meaningful communication, ask questions, participate and make their own decisions. A strengths-based non-judgmental approach, transparency, and prompt and accurate responses can facilitate cohesive working partnerships. In addition, maintaining regular contact and being reliable and accessible to people fosters collaborative relationships.

Case managers are part of the ADHC Community Support Team. The role of the Community Support Team (CST) is explained in a brochure that can be given to the person with a disability, their family and/or carer. It provides CST contact phone numbers for each region, and is available in the following languages:

Arabic; Croatian; English; Greek; Italian; Korean; Serbian; Simplified Chinese; Spanish; Traditional Chinese; Turkish; and Vietnamese

2.1.1 Practice Points

Following a service request, it is the responsibility of the case manager to make contact with the person with a disability and, where appropriate, their family and/or carers. It may not be the first contact the person has had with ADHC.

Preparing for engagement

- Read, collate, and understand any existing information about the person and their family and/or carer, including the referral report, Client Information System (CIS) data, and historic ADHC files and be aware of any other professionals involved with the person. While this can minimise repetition of fact finding questions, it is vital to hear the perspective of the person and carer first hand, rather than relying on secondary sources of information. Any other sources should be checked with the person for accuracy.
- Gain an understanding of the skills and forms of communication of the person. i.e. communication aids, culture, language and disability. Consider what will facilitate communication and engagement.
- Determine how you will explain the case management process to the person, including your role and that of their family and/or carers.
- Depending on the age and circumstances of the client, you will need to consider what engagement strategies you would use to support the identification of priorities. You may use the person centred thinking tool – 'important *to* and important *for'*.

Ways to achieve positive engagement

- Explain the case management process to the person, including your role and the family and/or carers.
- Discuss with the person how they wish to engage individual members of the family and the family as a whole. Engaging family members, informal supports and identifying family strengths is a critical part of supporting a child or young person with a disability.
- Take time to learn about the person's specific cultural needs and use communication styles that reflect an understanding of these.
- Explain confidentiality and exceptions to confidentiality, such as protecting child safety.
- If appropriate, written documents should to be translated by an accredited translation service for the person and their family to understand.
- Whenever possible, an accredited interpreter will be employed to support communication with individuals and families who do not speak English. Face to face interpreters are to be employed when meeting with the person or family whenever possible. Telephone interpreter services are to be employed when contacting the person or family by telephone. It is not appropriate to use children, regardless of their age, to translate for parents or other family members.
- Regularly communicate and stay involved with people, their families and /or carers and appropriate stakeholders within set timeframes to maintain active engagement.
- Establish and maintain open, two way communication in a format that is appropriate to the person.
- Set and meet timeframes for appointments at times that suit the person.

- Provide relevant information in a transparent format, establishing realistic and achievable timeframes.
- Remember names, relationships and be aware and respectful of family routines, beliefs and significant events.

Indicators that engagement is being achieved

The person with a disability and their family and/or carers are:

- Sharing information with you.
- Interested in and committed to the process or actions.
- Listening to and considering your suggestions and offering their own suggestions.
- Making contact to advise of any changes to their circumstances or actions they have taken following meetings.
- Taking responsibility for following up on agreed actions or proposals.

What to do when engagement is difficult, or not achieved

- Discuss the issues with the person and their family, where appropriate.
- Reflect on your communication style.
- Identify the reasons why engagement might be difficult, for example, has the person/ family had previous discontent with ADHC or another agency.
- Find solutions to the issues and problems, where possible.
- Try to identify other resources which may assist you.
- Seek advice from your manager.
- When the person with a disability is a child or young person, a risk assessment should be undertaken regarding actual or potential risk resulting from non-engagement. Depending on the outcome of this assessment, further action may need to be taken by the case manager in the interests of the child.

Accountability

- The case manager should outline the responsibilities of ADHC in relation to duty of care, sharing of information and potential risk of harm to any individual. This may or may not be in the context of child protection.
- ADHC's privacy policy should be explained to the person with a disability, and further information provided if the person requests.
- Consent is required from the person with a disability to commence the case management process and to talk about them with another service, agency or person. The person with a disability must be informed about the type of information that will be passed to another person or service about them, and the purpose for which the information will be used. The person has the right to refuse to consent to part or all of this process and their refusal should be respected.

- Consent for the disclosure, gathering or exchange of information must be obtained in writing. The full policy is available at Decision Making and Consent Policy and Procedures.
- There may be situations where there is a legal mandate or a requirement under duty of care to exchange or provide information to a third party where the explicit consent of the person with a disability and/or their family is not required and in fact could be detrimental.
- The new Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 clearly prioritises the safety, welfare and wellbeing of a child or young person over an individual's right to privacy *(see page 2 for details)*.

CIS Recording and Administration

- Use CIS to record any work undertaken in this and all future phases. For example, Minimum Data Set (MDS) recording hours (activities); case notes documenting any actions completed including all contact with families or agencies/service providers; current documents should be scanned or attached to CIS.
- Consent documents should be on CIS.
- Check the case is allocated to you on CIS. And the relevant data e.g. nature of disability and other required information is also recorded.
- All case notes recorded on CIS should be objective, concise, and factual.
- Document all actions/tasks completed by the case manager. This may include, for example, contact with the family/client and service providers; meetings attended and outcomes, documents/applications sent/submitted, and conversations with your manager or other team members regarding the client and family.
- It is useful to record contact and other details of agencies you have used, such as phone numbers and contact names of an interpreter service or the hours of availability of a service provider for future reference.
- Language in case notes needs to be strengths based.
- Ensure a CST file is created and all relevant documents for this client/family are placed on the file. The file should always be kept in a secure location.

2.2 Assessment

Assessment is a dynamic and ongoing process where information is gathered from a range of sources about a person, including their life situation, and formal and informal supports. The range of information is then considered in the context of information and advice from the person with a disability, their family and/or carers and informal supports. Information may be obtained from a range of sources, including written reports or records, verbal reports and observations and impressions of the ADHC case manager.

Any information available should be reviewed and analysed for its currency and its quality, keeping in mind the source of the information. ADHC case managers need to consider how they interpret any historical information, as well as what they choose to highlight. In some instances information relevant some years ago may no longer be significant, accurate or important.

Relevant information can be used to inform future discussions with the person with a disability, family and / or carers and used to assist the person with a disability to achieve their goals.

Assessment is not simply a process of obtaining information. It is a collaborative phase with the active involvement of the person with a disability. It is paramount that the person feels that he/she has been listened to, and that his/ her current circumstances and needs are well understood. Assessment identifies the person's strengths, assets, resources, needs, goals and wishes. It also identifies the existing supports and resources available to and being used by the person with a disability and their circle of support.

Assessment also includes identifying any difficulties the person may be experiencing in areas of their life including personal and community relationships, their health, and environment. It may be appropriate to bring together other sources of information including verbal and written reports to inform this process.

It is important to be clear about the purpose of any assessment. This will influence the nature of what is discussed and the information being sought. For instance, an assessment for respite and accommodation undertaken following previous, more comprehensive assessment will be different from a comprehensive assessment undertaken during the earlier stages of getting to know a person with a disability.

The process of assessment may be influenced by the need to collect specific types of information. However, whatever its purpose, its value and impact on the individual will be influenced by the nature and quality of the relationship between the person seeking the information and the person with a disability.

Throughout the 7 Phases, ADHC case managers must also be aware of and assess risks to the person with a disability, and themselves. ADHC case managers need to able to identify and develop strategies to manage risk. The full policy is available at Client Risk Policy and Procedures.

2.2.1 Practice Points

- Identify and collate information already available relevant to the assessment. This might provide the opportunity to verify or update information and could reduce needless repeat questioning.
- Analyse the information you have collected identifying what is and is not significant to the assessment.
- Consider which assessment tool is required.
- Seek only additional information related to the agreed purpose of the assessment.
- Identify, analyse and document current and potential risk factors and whether this warrants referral for a specialist assessment.

The assessment process

Assessment is undertaken via a range of activities that may include home visits, family meetings, reading and analysing reports, other stakeholder meetings and observation.

- If arranging meetings consider who should be present, the location, individual circumstances, timing and so on. Primary consideration is given to the circumstances of the person with a disability.
- In all activities be punctual and reliable, and avoid postponing or changing times.
- Observe family customs and rituals.
- Provide information to people and their families and/or carers about the purpose of the meeting and outline their rights and responsibilities and those of yourself and ADHC.
- Discuss with the person why the information is needed and how it will be used and stored.
- Spend time listening to the person and family and/or carer.
- Ask the person with a disability about their needs and preferred solutions and incorporate it into the assessment.
- Document and communicate the person's assessment needs in a form of communication and language that can be understood by the person being assessed.
- Use strength based language when documenting the stories, circumstances, needs and wants of people with a disability.
- The priorities of the person with a disability may not be consistent with those of the family and/or carer. Consider the strategies/ approach you adopt to balance any conflicting goals and priorities, while supporting the person with a disability.

Accountability

- The collection, provision or exchange of personal information in any form (verbal or written) must always be in compliance with the NSW Privacy and Personal Information Protection Act 1998. Further information is also available on the intranet at ADHC - Privacy. A fact sheet on information exchange has been developed for ADHC staff in relation to information exchange relating to children and young people.

CIS Reminder

- Ensure all assessment formats/templates used are attached or scanned into CIS.
- Case notes should indicate the rationale for choosing a particular assessment tool and may document the process used to conduct the assessment, for example, interviews or meetings, if this is not clear from the completed assessment.
- Ensure the date of commencement and completion of the assessment is recorded on the document or on CIS.

Tools

Selection of tools will depend on the person with a disability's individual circumstances.

Document Key

📖 ADHC case management document to be used by case managers.

Ⓟ Helen Sanderson Associates person centred practice resources - can be used to encourage and support sharing of power, building a shared picture and capacity for change.

🗣 Service or program specific tool to be used for specified service referrals, assessment and planning.

Key	Assessment Tools	Description
Ⓟ	**All about me, my family and friends**	To gain a better understanding of the person and their family supports
Ⓟ	**Families Dream for the Future**	Family friendly document that is easy to use to understand and respond to things that are important to a family
Ⓟ	**Important To and For**	To understand the difference between what is important *for* a person and important *to* them
Ⓟ	**Working / Not Working**	To identify what supports both formal and informal are working and not working, from both a client and Practitioners perspective
📖	**Case Management Assessment Report**	Case management assessment tool
📖	**Community Access Team Client Needs Assessment - Strengths Based**	Comprehensive strengths based needs assessment which includes: health, medical, family supports, environmental circumstances, support networks, service provision history, communication and care needs, community participation
📖	**Checklist for completion of needs assessment**	
📖	**Initial Contact Risk Assessment**	Risk assessment to be complete prior to undertaking an initial home visit
📖	**Nutrition and Swallowing Checklist**	To be used in consultation with a health care professional and the person with a disability and their family or carer. Applies to ADHC operated and funded accommodation support services and centre based

		respite services. Nutrition and Swallowing Policy
🕮	**Client Risk Profile**	Comprehensive risk assessment tool used to assist staff to manage risks that may arise while providing support to clients whatever the situation or location so that adverse effects on lifestyle, health, safety and wellbeing are minimised. Client Risk Policy and Procedures
🕮	**Family Assessment Framework – Information Package**	Information about conducting family assessments
🕮	**Family Assessment Framework – Facilitation tool**	Facilitation tool that addresses family strengths and protective factors to identify resources that can support the family's ability to meet its needs and better protect the children
🗣	**How Big is the Risk CRP – 2 – MCRA 1**	Risk assessment to be used for respite, school and accommodation only
🗣	**Home Alone Assessment**	A risk assessment tool to be used only in circumstances where people live independently in their own home
🗣	**Leaving Care Program Needs Assessment Leaving Care Needs Assessment**	Tool to build transitions for young people leaving care. To be used in conjunction with the DADHC Leaving Care Operational Guidelines 2009.

2.3 Planning

The goals, needs and wishes of the person with a disability identified in the assessment process, form the basis of a plan. A plan is a map of actions that documents the interventions, actions, responsibilities and timeframes needed to meet the identified goals. Interventions and actions may be immediate, short term or future focused. Future focused interventions anticipate a persons' changing life circumstances and recognise the role of prevention.

Planning is a continuous and fluid process that explores the ongoing and changing needs of a person throughout their life each time you engage with them. It is flexible and person centred, incorporating what is important *to* as well as important *for* a person. Planning considers the person's familial, environmental, cultural, economic and social circumstances as well as their formal service needs. Emphasis is placed on increasing independence, valued status and overcoming barriers to active participation in community life. This involves going beyond formal services and considering how to recognise and build on informal and natural supports that can create and sustain the life a person seeks.

The planning process involves collaboration between the person, their family and/or carers, others with a key contribution to make and the case manager. Consideration needs to be given to how you and the person develop a plan. Planning is a process that might involve a range of activities, including a formal planning meeting.

The case manager has a facilitating role in helping to identify and prioritise their goals and co-ordinate the contributions in a plan. Critical to achieving positive outcomes in planning is enabling the person to determine their goals, to consider their choices and decide on interventions. Where goals involve multiple agencies and/or a mix of formal service types, consideration should be given to the development of a single plan that integrates all contributions.

Plans are mutually agreed and should support and develop the person's ability to access formal and informal supports, and resources. Overall ownership of the plan rests with the person with a disability.

2.3.1 Types of plans

A review of the assessment report and any other relevant information will assist in determining if a specific type of plan is required. All plans will be person centred.

Person centred planning places the person with a disability at the centre and remains flexible to reflect the person's circumstances, culture, lifestyle and needs. Planning actively includes significant others, as identified by the person, such as family and friends. It is future orientated, prioritising a person's capacities, abilities and aspirations, what is important to them now and for the future. There is a shared commitment to action to create changes that a person and those close to them agree will improve their life. Core to the approach is the need for continuous listening, learning and response to the changing needs of the person.

2.3.2 Practice Points

Preparation

Prior to planning taking place, the ADHC case manager will have:

- Obtained relevant information, both factual and experiential, and reports from the intake and case management assessment phases.
- Completed an assessment of the person's communication needs to ensure their active participation in directing the planning meeting.
- Discussed with the person the purpose and context of the planning process, ensuring that they have time to consider what they want to achieve from their plan.

Planning meetings

In a planning meeting:

- The person with a disability directs, how, when and where the meeting will take place and who will be present.
- Active engagement from all parties is encouraged and facilitated by the ADHC case manager.
- The ADHC case manager is the activator, who asks questions, listens and engages in conversation to hear what is important 'to' and important 'for' the person with a disability.
- Information is gathered and provided in a form which best meets the needs of the person, such as visual, audio, web, translation, written or graphics.
- Discuss information obtained in the assessment phase and discuss possible, appropriate interventions to arrive at satisfactory strengths based approaches, which considers informal and community networks.
- The person with a disability is given appropriate information and choices about formal service options and the opportunity to make independent decisions about which option best suits their needs.
- In situations where another person is appointed to help the person with a disability in decision making, the person with a disability is always to be consulted and involved in making decisions.
- Consider the rights of the person with a disability to make informed decisions, which at times may not be supported by significant others in their lives.

When unsure about referring to a legally appointed Guardian to assist the person with a disability in decision making, the ADHC case manager should check documentation detailing the Guardian's function for the person with a disability and can contact the Guardian to seek their advice.

- Some decisions that may require the involvement of a Guardian concern:
    - accommodation - to decide where the person should live.
    - health care - to decide what medical and dental practitioners the person should see.
    - consent to medical and dental treatment - to act as the person's substitute

decision-maker about medical and dental treatment proposed for them by others.

- services - to authorise others to provide personal services to the person (usually to assist them to remain in their own home).
- in situations where the person with a disability requires support to manage their finances, a financial manager may be appointed through the guardianship tribunal to manage their financial affairs and to make important financial decisions on their behalf.[1]

Recording the plan

The following are the minimum requirements to be recorded on a person's plan:

- Date, location and participants in the planning process or meeting.
- Person centred orientation, telling the person's story and individual circumstances.
- Things the person with a disability wants, their strengths, life goals and what is important to and for the person, with an outcome focus.
- Potential risk factors, concerns or difficulties, and strategies for prevention, including how to respond to these.
- Mutually agreed goals and interventions, either informal, mainstream or specialised, to implement the plan.
- Timeframes, roles and responsibilities of all involved in the plan.
- Strategies for ensuring the person's cultural, financial, lifestyle and linguistic circumstances are respected.
- Identified interventions and activities that are flexible and dynamic.
- Signatures of all involved in the plan.
- Review date for the plan is agreed to and recorded.

Good Practice

Aspects of a good plan:

- Ownership is held by the person with a disability.
- Addresses the area(s) of a person's life that is (are) of most concern to her / him and the people who care about her / him.
- Identifies natural supports.
- Identifies opportunities for community participation.
- Has the backing of the person and the people around her / him.
- Provides a bedrock for future action.
- Does justice to the person in the way it describes her / him.
- Identifies achievable goals.

[1] Decision Making and Consent Policy and Procedures. Accommodation Policy and Development Directorate. NSW Department of Ageing, Disability and Home Care. Issued July 2008 Amended February 2009

- Implementation strategies are realistic.
- Accurately reflects what has been agreed.
- Is unique to the individual.
- Is specific, clear and accessible[2].
- Goals are supported by well documented tasks expected to lead to goal realisation.
- Each task has a person allocated as responsible for completing.
- Clear agreement with all stakeholders on how the plan will be monitored.
- The template or document has space on the plan to record progress against agreed goals.

CIS Reminder

- Planning documents should be attached or scanned into CIS.
- If planning meetings were held and minutes taken these should be available on CIS.
- It is helpful to record in case notes when and where a planning meeting occurred if all other information and notes are contained in attached documents.
- The plan should include signatures of all involved in the plan.
- Review date for the plan is agreed to and recorded

Tools

Selection of tools will depend on the person with a disability's individual circumstances.

Document Key

 ADHC case management document to be used by case managers.

Ⓟ Helen Sanderson Associates person centred practice resources - can be used to encourage and support sharing of power, building a shared picture and capacity for change.

 Service or program specific tool to be used for specified service referrals, assessment and planning.

Key	Planning Tools	Description
Ⓟ	**One Page Profile to Person Centred Plan**	Diagram demonstrating the relationships between person centred assessment tools to inform planning
Ⓟ	**Families Dream for the Future**	Family friendly document that is easy to use to understand and respond to things that are important to a family
Ⓟ	**All about Me, my family and friends**	To gain a better understanding of the person and their family supports
Ⓟ	**The Doughnut**	Reflective tool for the case manager which helps identify specific responsibilities - core responsibilities,

[2] Helen Sanderson Associates Person Centred Thinking & Planning Training

		using judgment and creativity and what is not a paid responsibility.
Ⓟ	**Important To and For**	To understand the difference between what is important *for* a person and important *to* them
Ⓟ	**Support Plan Graphic**	Maps a person's goals and activities using all person centred assessment and planning tools.
🕮	**Client Case Management - Case Plan / Review**	To be used alongside the Case Management Assessment Report
🕮	**ADHC Family Centred Plan**	
🕮	**ADHC Person Centred Plan**	
🕮	**Client Risk Management Plan**	Plan to describe actions identified in the Client Risk Profile
🕮	**Service Plan Meeting**	Meeting tool for planning and prioritising
🗣	**Individual Planning for Children and Young People**	Comprehensive planning document for children and young people that also includes a client profile
🗣	**Client Transition Plan – Group Homes**	Plan to be used when a person moves into new accommodation
🗣	**Community Services NSW / ADHC Client Transition Plan**	

2.4 Implementation

Implementation is the process of putting into action the plan developed by the ADHC case manager, together with the person with a disability, their family and/or carer. The aim of implementation is to help the person with a disability achieve their goals and desired outcomes, identified in the assessment and planning phases.

The level of involvement by the ADHC case manager may vary through different stages of implementation. This allows the person with a disability, their family and/or carer to lead the implementation of some stages of their plan.

Implementation can occur at three levels:

1. The person with a disability:

   Once the plan has been developed in collaboration with the person with a disability, goals should be prioritised, desired outcomes identified and strategies agreed on, taking into account the range of informal and formal enablers and constraints.

2. Family, friends, supporters and community:

   When needed providing assistance to family, friends and supporters to build knowledge, skills and resources that will support them and the person with a disability to meet the identified goals.

3. Systems intervention:

The ADHC case manager working at this level will undertake a range of tasks. For example,

i. analysing the strengths and constraints of the service systems;

ii. defining and responding to issues within the person's immediate context and/or in the service system which may improve the person's quality of life; and

iii. assessing the effectiveness of strategies and continuing to revise desired outcomes and strategies.

2.4.1 Practice Points

- Ensure that the person with a disability and their family and / or carer drive the process as fully as possible.
- Everyone involved should know what the overall implementation plan is, not just what their part in the plan is. This helps to:
  - ensure that everyone knows how and when they are participating, the significance of their contribution and the role that other key stakeholders have in the process.
- All stakeholders should be informed of, and understand, their role and that of others in the implementation process. This helps:
  - ensure that everyone is aware of the expectations and importance of their role.
  - participants understand how they contribute to the overall success of the plan and its implementation.
  - facilitate ongoing positive, engaging relationships.
- A clear coordinated process that is inclusive and communicated effectively helps to lay the foundation for successful implementation and the achievement of their goals.

CIS Reminder

- Maintain current progress notes, as good recording of activities in this phase will assist the review process.
- Record any changes to the original plan and agreements made with the person and family.
- Record progress against actions, either in the planning template if possible or alternatively in case notes in CIS.
- Adjust the record so that previously identified options and intervention that the client and family no longer wish to pursue are recorded in CIS notes as completed.
- Record all contact with external or internal parties.

Tools

Selection of tools will depend on the person with a disability's individual circumstances.

Document Key

 ADHC case management document to be used by case managers.

Ⓟ Helen Sanderson Associates person centred practice resources - can be used to encourage and support sharing of power, building a shared picture and capacity for change.

 Service or program specific tool to be used for specified service referrals, assessment and planning.

Key	Implementation Tools	Description
Ⓟ	**Families Dream for the Future**	Is a family friendly document that is easy to use to understand and respond to things that are important to a family
Ⓟ	**All about me, my family and friends**	To gain a better understanding of the person and their family supports
	**Service Plan Meeting**	Meeting tool for planning and prioritising
	**Service Request Form**	

2.5 Monitoring

Monitoring is an active and ongoing process where aspects of the planning and implementation phases are reviewed. It identifies the effectiveness and relevance of planned goals, focusing on the timeliness and success of strategies being used to achieve these goals. Additionally, it provides the opportunity to adjust the plan to address any unanticipated problems.

Agreement should be reached with participants on how actions within the plan are to be monitored, as part of the planning process.

Importantly, it also helps to identify any changes in the person's circumstances or environment which may result in the need to change or modify the plan in order to prevent crisis situations developing.

ADHC case managers are responsible for obtaining feedback in order to support consistency in this phase. Responsibility for monitoring also rests with the family and / or carer and support networks of the person with a disability who have been involved in the planning process, however the ADHC case manager coordinates this process.

The ADHC case manager speaks with the person with a disability, family and/or carer and all others involved in implementing the plan, to check on progress against agreed goals and actions. They ensure the key driver for this process is the expressed view of the person with a disability.

The ADHC case manager is also responsible for ensuring organisational requirements in relation to recording and reporting are met.

2.5.1 Practice Points

- Maintain rapport and communication with the person with a disability and their family and / or carer so that information regarding the quality and effectiveness of the plans and actions can be disclosed.
- Consider how to use the information collected.
- Assess how the person with a disability is being supported in realising their goals:
    - Does the person with a disability, their family and / or carer require any further support or information to achieve their goals?
- Maximise the opportunities for the person with a disability to be involved in setting new goals, actions and techniques to monitor progress.
- Document any findings and respond in a timely and appropriate manner.
- Maintain ongoing communication with all stakeholders involved in the case plan to ensure progress against agreed case plan activities.
- Adjust services, support and interventions to meet the needs of the person and where interventions have not proceeded as expected.
- Consider service system adjustments or improvements, where interventions have not been carried out or have been ineffective.

2.6 Review

Case management practice involves regular formal and informal review processes. The review phase is important to help ensure that outcomes for people are relevant to their needs and include a focus on community inclusion and participation. The review process should be driven by, and inclusive of, the person with a disability and how they feel the process is working.

The review phase should adhere to the following principles;

- Ensure that case management is about identifying strategies to support the needs of the person in the most appropriate way.
- Focus on finding a balance between what is important to the person, and what is important for the person.
- Look at the mechanisms built into the assessment, planning and monitoring tools.
- Can be formal or informal and should be recorded in the most appropriate way depending on the type of review.
- Involve the person in regular informal and formal reviews, and parent(s)/guardian, family and / or carer and support people where appropriate.
- Ensure people involved in the review are informed and educated about the process.
- Involve service and supports where appropriate.

The person with a disability, an ADHC case manager or ADHC management may ask for an immediate review if a person's situation becomes complex or critical.

2.6.1 Practice Points

Reviewing a person's plan

A good review of a person's plan will be characterised by the following elements:

- Achievements: What has been achieved to date? For example has the person been more involved in the community; do they have more confidence; do they see their future differently? What wasn't achieved? Why and what could be approached differently?
- Relevance: Do the achievements relate to the original goals set?
- Change: Did anything change along the way such as a change in personal or family circumstances or health status?
- Outcomes: What were the most significant positive outcomes for the person with a disability? How have the outcomes made a difference?
- Next Steps: How can these points be addressed in future planning activities?

Responses to all the above questions need to be taken into account for subsequent planning. A collaborative review of the whole plan to see if the identified goals have been achieved and if what the person with a disability wanted has occurred, is also required. They identify achievements, fulfillment and areas requiring more attention and new or emerging issues, concerns or aspirations.

The review outcome directs the continuation of the relationship between the person with a disability and the ADHC case manager. This may include revisiting formal planning, identifying areas of the initial plan that require more support, reassessing or engaging in the development of a futures plan.

Depending on the purpose of the review, an ADHC case manager may review any of the planning strategies and resources used as part of the implementation and planning processes. These may include, but not be limited to:

- Person Centred Plan
- Consent and exchange of information
- Previous assessments
- Client Risk Profile
- Client Risk Management Plan
- Medical / health plans and protocols

Other considerations to be explored in the context of a review process will include but not be limited to:

- Eligibility for Community Access
- Decision making capacity of the person
- Decision making capacity of a parent or guardian
- Services and/or supports involved
- Review for closure

CIS Reminder

- Ensure the outcomes of a review with a manager and/or the person/family are recorded on CIS.
- Comments, directions or advice of a manager should be recorded.
- Preparation for a case review with a manager should include checking all CIS data entry is up to date; all documents are filed correctly on the paper file; and any relevant documents are located on CIS.
- The review context is a good time to check via CIS self report that all information for a person is comprehensive and accurate. This will ensure ongoing currency of information recorded on CIS; prevent needing to spend a significant period of time in the future completing CIS entries for multiple clients; and discourage the practice of completing CIS data entry immediately prior to an MDS snapshot date.

Tools

Selection of tools will depend on the person with a disability's individual circumstances.

Document Key

📖 ADHC case management document to be used by case managers.

Ⓟ Helen Sanderson Associates person centred practice resources - can be used to encourage and support sharing of power, building a shared picture and capacity for change.

🗣 Service or program specific tool to be used for specified service referrals, assessment and planning**.**

	Review Tools	Description
Ⓟ	**Families Dream for the Future**	Family friendly document that is easy to use to understand and respond to things that are important to a family
Ⓟ	**All about Me, my family and friends**	To gain a better understanding of the person and their family supports
Ⓟ	**Working / Not Working**	To identify what supports both formal and informal are working and not working, from both a client and practitioner perspective
Ⓟ	**Important To and For**	To understand the difference between what is important *for* a person and important *to* them
Ⓟ	**Review Plan Graphic -4 +2**	To review progress and outcomes with a client, looking at learning, concerning and actions.
📖	**Client Case Management - Case Plan / Review**	To be used alongside the Case Management Assessment Report
📖	**Service Plan Template Client Handover**	For use review prior to handover to other service
📖	**Request Form for Extension Beyond 6**	Request to continue to work with a client

	Months Intervention Plan	
🕮	**Case Review Template**	Template to use with manager and families and / or carers
🕮	**Disability Client Three Monthly Review**	
🕮	**A Service Planning Tool; A Review and Closure Tool**	
🗣	**Action Plan – Complex Case Review**	Strengths based review tool for complex cases
🗣	**Complex Case Meetings –Review of complex case form and service feed back form**	
🗣	**Community access Complex File Review Report**	

2.7 Closure

Cessation of involvement by an ADHC case manager or the closure of a file may be influenced by a number of factors. These factors may relate to organisational or agency requirements in which a limited time frame is identified for ADHC case manager involvement with any one client. This may raise significant concerns or questions as to the appropriateness of terminating contact. The decision as to whether to cease involvement or close the relationship can be influenced by a number of factors.

Agency considerations might mean that case management was intended to assist with a specific set of issues over a limited time period and the relationship must be ended. Even so, new issues may emerge that raise significant concerns or questions as to the appropriateness of terminating contact.

A review should always be conducted prior to considering closure. The ADHC case manager, in partnership with the person with a disability, can then identify any issues or matters of concern that may require ongoing support or assistance.

Where agreement is reached that goals have been met and the person with a disability, their family and carer will not benefit from continued case management, the relationship can be ended. Where a person's support needs are long-term and complex, they and their family and/or carer might seek a continued relationship with ADHC case managers. This might involve a futures planning approach of jointly anticipating developmental changes for the person and/or their family and carers, and agreement to renew contact at times those times.

Futures planning is an approach to working with a person with a disability and their family to support them to identify what they want for their future. It recognises that people have goals and a vision for the future beyond service and support. When it is agreed that no current case management involvement is needed, it may be agreed that contact is to be resumed at a future time, for instance in preparation for a future significant life transition.

In other circumstances, closure may be prompted by a person with a disability, their family and / or carer making a unilateral decision not to continue contact with the ADHC case

manager. Such a decision may also be made in collaboration with the ADHC case manager and be reached following achievement of goals identified in the plan.

The capacity for ADHC to provide ongoing support through avenues other than case management should be identified and discussed with the person.

Ideally in the context of futures planning and Agency requirements under ***Keep Them Safe – A shared approach to child wellbeing***, an ADHC case manager may commit to building a longer term relationship without identifying an end date. In some instances, contact can be intermittent and suspended for periods of time.

2.7.1 Practice Points

The following considerations should be given and actions taken in the context of closing a file:

- The goals have been attained from the person's perspective and the person has the capacity to self manage, i.e. make decisions independently or with own their supports.
- Where the closure of the file is initiated by ADHC and case management support is being ceased, it should not be a surprise to the person with a disability.
- The person with a disability, their family and/or carer knows how to get back in touch with ADHC, should they need to in future.
- Closure is process in which the person with a disability is prepared for the event.
- Such preparation should include:
    - review of plans and acknowledgment of achievements.
    - consideration of ongoing issues and how these might be addressed; this may involve referral to internal or external supports either formal or informal.
    - discussion about involvement of other ADHC staff members and how and when this is likely to occur.
    - with permission of the person with a disability, advice to key people who have been part of the process of your involvement that you will be ceasing contact with the person with a disability.
    - it may also be appropriate to identify future issues.
- The person has requested that they no longer need case management support.
- Where the person with a disability, their family and / or carer ceases the contact the following considerations should guide any subsequent action by the ADHC case manager:
    - concerns of any kind for the safety of the person with a disability or the safety of others in contact with this person.
    - in the case of a child at risk or concern for potential at risk situation reference should be made to the ADHC policy and protocols.
    - in other circumstances where the above situations do not exist, it may be appropriate to send a letter to the individual, family and / or carer to acknowledge cessation of the contact and confirm opportunity to re-contact should they wish.

CIS Reminder

- Information recorded on CIS needs to include: the rational for closing a case; contact with your manager regarding closure of the case; contact/discussion with the person or family re closure and their response; and actions taken to provide information to other parties if for instance the case is to be transferred to another case manager/location.
- A progress note should be included on CIS recording the date the case was closed.
- Correspondence sent as part of closing a case should be attached to CIS.
- A progress note needs to be made on CIS indicating where the file is now located

Tools

Document Key

 ADHC case management document to be used by case managers.

Key	Closure Tools	Description
	**Review for closure**	Assists the case manager to review decisions to consider closure with a person

2.8 Guide Review

The *Case Management Practice Guide – 7 Phases of Case Management* will be reviewed after 12 months. The review will allow tools and templates to be updated, ensure the guide reflects effective, contemporary case management practices and that it remains relevant to the needs of people with a disability.