# 3.2 Support Planning

## 3.2.1 Support Planning and Service Agreement Collaboration Policy and Procedure

### 3.2.1.1 Purpose

Nepean Centre aim is to work with participants, families, advocates, communities, and other providers to achieve the best outcome for the participant. This collaboration allows all parties to share ideas and knowledge to ensure that the supports are relevant, appropriate, and in line with the service agreement.

### 3.2.1.2 Scope

Nepean Centre is committed to ensuring that our staff understand the beneficial aspects of a collaborative approach for the participant.

### 3.2.1.3 Policy

Support plans place the participant's voice and requirements at the centre of developing their successful outcomes. Staff will be persistent and patient in building relationships with participants. Our team will promote a shared understanding of the participant's preferences, expectations and needs across the mainstream, community, and formal and paid supports. Support plans will include the following:

- strategies to actively engage and build relations with participants who interact with multiple programs and supports
- guardianship and supported decision-making, and compulsory treatment orders
- strategies in navigating complex, ambiguous or conflicting service demands, ethical and regulatory environments

This collaborative approach requires staff to work with relevant parties when:

- locating key workers with a family and another provider
- working with other providers in the supply of supports or services
- assisting the participant in transitioning and exiting the service
- work with the participant and their network to develop relevant and proactive strategies
- building the participant's capacity
- planning with supports for the participant
- setting participant goals
- developing person-centred strategies
- developing emergency and disaster plans
- developing service agreements.

Staff must cooperate with other agencies in the delivery of service. This collaboration may include initial contact, sharing ideas and input from the participant, their families and advocates, following through on the ideas of a provider, and actively listening to discussions.

We will collaborate with all relevant parties to allow participants to access a service network that meets the full range of needs. The Disability Support Manager will establish communication with the relevant service provider, so our organisation can maintain collaborative relationships and protocols and participate in networks with relevant agencies.

Information, knowledge and skills are communicated and shared between the participant, family, advocate, provider, and other collaborating providers. Nepean Centre will work with the participant and their family and advocate to ensure that the participant maintains functionality.

### 3.2.1.4 Procedure

#### *3.2.1.4.1 Keyworker*

Participants and families may need assistance locating the right person to work with the participant. To do this, our team will undertake the following process:

1. Discuss the participant's requirements with the participant, family/carer, and advocate.
2. Gain formal written consent to share and gather information with other providers.
3. Contact other service providers working with the participant to collaborate and determine the criteria.
4. Identify at least one (1) key support worker to contact participants, family/carer and advocate, and the other providers.
5. Inform the participant, family, and advocate of the identified person for their approval.

6. Collaborate with the participants, family/carer and advocate to identify continuity of care backup support
7. Record the process undertaken and the results in the participant's service agreement.

### *3.2.1.4.2 Supporting participants*

Staff creating the support plan must understand the participant and their requirements and undertake the following:

- Work with the participant to make sense of their NDIS plan and understand how they can use it and how it links to other services or plans in the participants life.
- Build an understanding of participants' capabilities and support them to maintain and build their capacity and resilience to achieve my goals.
- Support the participant to be creative and think outside the box to find and negotiate solutions that meet my goals.
- Provide information and tailored opportunities for the participant to explore and expand their vision for their future and what it means to have a good life.
- Share current best practices to support the participant in making connections and find information about support options.
- Alert the participants to real or potential conflicts of interest when planning and selecting supports, and work with them to make informed choices.
- Encourage the participant's specialised and mainstream service providers to recognise and challenge prejudice or lack of vision in service offerings and attitudes.
- Involve participants in understanding and designing safeguards to keep them safe while supporting their right to take risks and build independence.
- Seek input into our corporate governance to ensure our policies and practices reflect the needs of our participants and community.
- Work with participants to develop a way to respond to emergencies, crises, and foreseeable life events.

### *3.2.1.4.3 Risk Management*

All participants must have the following risk documents completed and recorded in their files:

- Individual Risk Profile
- Safe Environment Checklist
- Personal Emergency Preparation Plan
- Support Plan

The above forms must be reviewed annually to safely encapsulate the participant's needs, preferences, and goals. Note: The Personal Emergency Preparation Plan must be trialled, adjusted (as required) and recorded.

Staff undertaking risk assessments must be approved by the Disability Support Manager. The risk assessment includes:

- Consideration of the degree to which the participant relies on our services to meet their daily needs
- The extent to which the participant's health and safety are affected due to disruption

### *3.2.1.4.4 Collaborating with other providers*

The Disability Support Manager or their delegate will make initial contact with other providers after obtaining consent from the participant, their family/carer and the advocate. Various methods will be used to maintain contact, e.g. email, phone and networking. All records of contact are kept in the participant Service Agreement.

### *3.2.1.4.5 Transition and exit*

The participant's needs, interests or aspirations may change during the delivery of their supports. These changes may lead to a need to transition to or exit from their current service. If this occurs, with the consent of the participant, we will contact the relevant service provider to:

- collaborate with providers and the participant to develop a plan of action
- request or send documents relevant to the participant
- confirm current supports, practices and needs to enable the participant to transfer or exit smoothly
- identify risks and develop a risk management plan
- develop a transition/exit process for the participant and confirm details with the participant
- work with the participant during the process
- review the effectiveness of the transition upon completion
- document the process in the participant support plan.

Risks associated with each transition to or from Nepean Centre are identified, documented, and outlined in our Transition or Exit Policy and Procedure and Risk Management Policy and Procedure.

#### *3.2.1.4.6 Capacity building*

The participant's capacity-building process is designed to improve and retain their skills and knowledge to maintain and improve their functionality.

To build and support the participant's functional capacity, Nepean Centre will collaborate with:

- a participant, their family/carer, and advocate to affirm, challenge and support.
- other providers to develop the participant's skills further and to improve practice and relationships.

#### *3.2.1.4.7 Participant outcomes*

Collaboration with a participant, their family/carer, and their advocate is the basis for ensuring functional outcomes focused on the participant's needs, priorities, and skills. This process includes:

- listening to every person
- analysing the information from each person
- determine relevant participant outcomes
- consult with all parties to reach an agreement on outcomes
- record the information in the support plan
- set a review date to ascertain if the participant reached the outcome required
- detailing collaborates in the service agreement

#### *3.2.1.4.7 Support planning*

During the assessment and support planning process, collaboration is undertaken with a participant, their family/carer or advocate to:

- complete a risk assessment (see 4.3 Risk Management)
- document a risk assessment
- plan appropriate strategies to manage/treat known risks
- create an emergency plan
- train staff in strategy implementation
- implement appropriate strategies to manage/treat known risks
- conduct an annual review, or earlier, according to the participant's changing needs/circumstances

##### *3.2.1.4.7.1 Support Plan document*

Staff completing the support plan must identify the participant's communication needs. This information will determine how they will present and inform the participant about their support plan. Staff must explain and provide the support plan in a mode of communication that suits the participant.

#### *3.2.1.4.8 Service agreements*

Nepean Centre will collaborate with the participant to develop a service agreement that establishes the following:

- expectations of both parties
- supports to be delivered
- conditions associated with the delivery of supports, including details of why particular conditions are attached.

With the consent or direction from the participant, Nepean Centre collaborates in the development of the support plan with other providers to:

- develop links
- maintain links
- share information
- meet the needs of a participant

### 3.2.1.5 Related documents

- Continuity of Care, section 11 of Support Plan
- Participant Information Consent Form
- Participant Safe Environment Risk Assessment
- Personal Emergency Preparation Plan
- Privacy and Confidentiality Agreement

- Risk Management Policy and Procedure
- Service Agreement
- Support Plan
- Support Plan – Easy Read
- Transition or Exit Policy and Procedure

#### 3.2.1.6 References

- NDIS Practice Standards and Quality Indicators 2021
- Privacy Act 1988 (Commonwealth)
- Disability Discrimination Act 1992 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)

## 3.2.2 Support Planning Policy and Procedure

### 3.2.2.1 Purpose

This policy outlines the legislative requirements and practice procedures for undertaking support services for NDIS participants. Our organisation will comply with the requirements of NDIS Practice Standards and Quality Indicators.

Compliance with this policy is a condition of appointment for all persons engaged in providing services on behalf of Nepean Centre.

### 3.2.2.2 Scope

To instruct our team on developing a support plan to incorporate the participant's wants, needs and aspirations. Support Plans include the type of staff and the time and length of the service linked to the registration group on a NDIS Plan.

### 3.2.2.3 Policy

All participants and their support networks are aided to collaborate and participate in developing a goal-oriented support plan. The support plan will reflect an individual's goals and aspirations and review the participant's strengths and functionality. The plan is based on the presumption of capacity and will safeguard the risks and needs of the participant.

The support plan incorporates both the participant's supports (described as the nature of a coordination, strategic or referral service or activity) and reasonable and necessary supports funded under NDIS (activities that support goals to maximise independence, allow to live independently and undertake mainstream activities).

The support plan will provide transparent written information to the participant outlining the services and type of support/s they will receive from Nepean Centre. The amended support plan will communicate changes in the participant's needs, preferences, or goals. This document must be readily accessible to the participant and their workers.

Participants are provided with the support plan in a mode of communication noted in their files. The support plan must be discussed and explained to the participant to implement adjustments and feedback.

Staff must be screened, trained, and qualified in their roles; all staff must hold current worker screening.

#### *3.2.2.3.1 Support planning principles*

- The support planning process is consultative, where the participant, family, friends, carer or advocate work together to identify strengths, needs and life goals, focusing on choice and decision-making.
- The participant's preferences, values and lifestyle choices should be supported (wherever possible).
- Support plans should promote the valued role of people with disabilities that is of their choosing.
- Nepean Centre promotes functional and social independence and quality of life.
- Support plans will contain goals.
- Agreed service choices should reflect the participant's personal goals.
- Support plans should be creative, flexible and not restricted to set patterns or methods of service delivery.
- The plan's activities and supports must include the participant's chosen communities and maintain connections with their community to allow active participation.
- If a participant identifies as Aboriginal or Torres Strait Islander, their community will be contacted to engage and support services.
- The support plan is reviewed regularly (at least annually) and amended to respond to participants' needs and preferences.

- The support plan should be strength-based, seeking to maximise independence and build on the participant's existing networks.
- The support plan should be provided to the participant in their first language or Easy Read, where appropriate or requested.
- Staff working with a participant must have access to and understand the support plan and Personal Emergency Preparation Plan
- Continuity of care backup support is identified in consultation with the participant
- Support plan must include preventative health measures, including vaccinations, dental check-ups, comprehensive health assessments and allied health services
- The participant or their advocate may request a review of the support plan.
- The staff developing the support plan will have the necessary skills and competence to undertake this function.
- The support plan be linked to the Personal Emergency Preparation Plan
- A participant with a disability will be facilitated to assist in the comprehension of their NDIS Plan, including:
    - understanding and self-directing their NDIS Plan
    - understanding the supports in their NDIS Plan
    - understanding funded support budgets
    - purchasing general funded supports
    - purchasing stated funded supports
    - managing and paying for their supports
    - choosing their providers
    - making agreements with their preferred providers.

### 3.2.2.4 Procedure

#### *3.2.2.4.1 Support plan development*

##### *3.2.2.4.1.1 Planning*

- Explain the support plan development process for the participant.
- Arrange a meeting time with the participant and, if applicable, their advocate or family.
- Develop the support plan with as much input, choice and decision-making from the participant as they want. Document the reasons for the decisions made (should a participant choose to have minimal input into their support plan).
- Staff creating the support plan must understand the participant and their requirements and undertake the following:
    - Work with the participant to make sense of their NDIS plan, and understand how to use it and how it links to other services or plans in my life.
    - Build an understanding of participants' capabilities and support them to maintain and build their capacity and resilience to achieve my goals.
    - Support the participant to be creative and think outside the box to find and negotiate solutions that meet my goals.
    - Provide information and tailored opportunities for the participant to explore and expand their vision for their future and what it means to have a good life.
    - Share current best practices to support the participant in making connections and find information about support options.
    - Alert the participants to real or potential conflicts of interest when planning and selecting supports, and work with them to make informed choices.
    - Encourage the participant's specialised and mainstream service providers to recognise and challenge prejudice or lack of vision in service offerings and attitudes.
    - Involve participants in understanding and designing safeguards to keep them safe while supporting their right to take risks and build independence.
    - Work with participants to develop an agreed way to respond to emergencies, crises and foreseeable life events
    - Be proactive in supporting preventative health measures, including vaccinations, dental check-ups, comprehensive health assessments and allied health services
    - Support and build participants' capacity and confidence
    - Negotiate with support and service providers, make transitions or adjust my plan, if relevant to their role, and inform the supervisor otherwise
    - Encourage the participant to navigate complexity, resolve issues and, maintain continuity and integration of supports, refer to the supervisor as required

- Create opportunities for the participants to practice and develop their capacity to manage and direct their supports
- Support participants to coordinate different and often disconnected services and support into an integrated experience.
- Identify breakdowns in support arrangements and work with participants and other service providers to adapt in response
- Identify emergencies and disasters by linking to the Personal Emergency Preparation Plan

- Before meeting with the participant, review the following:
  - Participant Intake Form
  - participant assessment information
  - referral documents
  - other relevant notes or data will assist in understanding the participant as an individual.

#### *3.2.2.4.1.2 Providing information to the participant*

- Emphasise to the participant why they must identify their personal goals and aspirations.
- Use the appropriate support plan as a prompt to assist the participant in identifying areas where Nepean Centre services may help them realise their goals.
- Outline the prompts on the plan, including a discussion of the participant's physical, emotional, spiritual, cultural, community, social and financial needs.
- Provide the participant with a clear understanding of their choices and service options available to make informed decisions about their choices and priorities.
- Explain to the participant any information-sharing requirements with other parties.
- Provide the participant with examples and suggestions of how Nepean Centre services may be able to help them achieve their goals.

#### *3.2.2.4.1.3 Facilitating the development of participant-centred goals*

- Work with the participant and their advocate/s to identify their personal goals.
- Ask the participant to identify the types of help or assistance most important to them.
- Help the participant recognise their strengths and capabilities.
- Transform the participant's goals into SMART (i.e. Specific, Measurable, Attainable, Realistic and Timely) goals, e.g.
  - Simple goal: To be able to collect the mail.
  - SMART goal: To walk to the letterbox, without assistance, every day to collect the mail.
- Set a time frame for each goal, so progress can be measured, e.g. walk to the letterbox without assistance to collect the mail and achieve this by November 30.
- Use the participant's expressed goals, priorities, and agreed-upon actions in developing their support plan.

Consideration will also be given to the following:

- financial resource capacities and any limitations of Nepean Centre services or specific programs to be utilised
- capacities, expertise and appropriateness of current Nepean Centre staff to provide services
- availability of specialised subcontracted staff or services, if applicable
- other services or individuals who will provide services as designated by the participant
- volunteer supports available
- determining (with the participant) how each goal will be measured so progress can be recorded
- identifying (with the participant) any potential barriers to achieving their goals and then developing strategies to alleviate those barriers
- working with the participant to prioritise their goals if many goals are identified. Each goal lists actions, responsibilities, frequency and duration of services to be coordinated or supplied on behalf of the participant. Document all the information in the support plan
- identifying and documenting a support plan, all stakeholders (e.g. participant, family, advocate/s, community engagement links and other services or agencies) will undertake to assist the participant in achieving each goal.

### *3.2.2.4.2 Support plan delivery and review*

- Negotiate specific days for services/supports and document them in the participant support plan.
- Where possible, agree upon time ranges to build flexibility into the service roster, e.g. start time between 1:00 pm and 1:30 pm and provision of one (1) hour of domestic assistance.

- If not finalised, negotiate service fees and record these in the participant's service agreement and the support plan.
- Ask the participant to sign the support plan to acknowledge their agreement.
- Ensure access to support plan by both the participant and their worker
- Agree on the criteria to evaluate the effectiveness of Nepean Centre service responses and document this in the support plan.
- Ensure that all involved stakeholders have copies of the agreed support plan.
- Explain to the participant that the Disability Support Manager will monitor the progress of the support plan
- Explain that the participant can request a support plan review at any time
- Explain to the participant that they are part of the review process (see Responsive Support Provision and Support Planning Policy and Procedure).

### 3.2.2.5 Related documents

- Risk Assessment Form
- Individual Risk Assessment Profile
- Participant Intake Form
- Participant Intake Checklist
- Participant Information Consent form
- Personal Emergency Preparation Plan
- Service Agreement
- Support Plan
- Support Plan – Easy Read
- Support Plan Review Report

### 3.2.2.6 References

- NDIS - Developing your first NDIS Plan
- NDIS Practice Standards and Quality Indicators 2021
- NDIS Workforce Capability Framework
- Privacy Act 1988 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)