Individual planning

Policy and procedures

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Accommodation Policy and Development Directorate
Department of Ageing, Disability and Home Care
September 2005

New South Wales Government

DADHC
Department of Ageing, Disability & Home Care

Document approval

The document ***Individual planning policy and procedures*** has been endorsed and approved by:

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1 Purpose

The purpose of this policy is to ensure that each person with a disability receives a service that is designed to meet his or her individual needs and personal goals.

2 Service type

Accommodation support services.

3 Legislative framework

Disability Services Act 1993 and Standards.

4 Target groups

Adults living in accommodation support services funded or operated by the Department of Ageing, Disability and Home Care (DADHC).

5 Position statement

All clients who receive an accommodation support service funded or operated by the accommodation service provider will have an Individual Plan (IP). The IP is a written agreement between the service provider and the client, their family, guardian, advocate and/or financial manager about the support services that will be funded or operated by DADHC to meet the identified client goals.

DADHC recognises the importance of consultation with the client and their family, guardian, advocate and/or financial manager in the design and provision of services to the client.

Clients who receive an accommodation support service from DADHC will have an IP or IP review within three months of entry. The IP is valid for twelve months and will be reviewed every six months.

The formal review of an IP is an opportunity for staff, the client and family, guardian, advocate and/or financial manager to evaluate previous goals and outcomes, and to develop new goals.

6 Performance requirements for services funded by DADHC

The implementation of the Individual Planning Policy is mandatory for both DADHC operated and funded services.

It is mandatory for services operated by DADHC to implement the individual planning procedures as detailed in following sections of this Policy document.

Funded services are not required to follow these same procedures in recognition of the varied organisational and operations systems that exist in the NGO sector. However funded services are required to have procedures in place for the development, implementation and review of IPs that are consistent with the Policy position statement and the Policy principles.

7 Principles guiding this policy

1. DADHC recognises that each person with a disability is unique. Staff respect the client's circumstances and respond in ways that are both fair and open.
2. Staff aim to promote and increase the independence of clients.
3. Each client's right to privacy, dignity and confidentiality in all aspects of his or her life is recognised and respected and protected in relation to personal activities.
4. When a person resides in a DADHC funded or operated accommodation support service, staff are responsible for developing an IP regardless of the role played by other agencies.
5. IPs enhance the client's life through greater community participation and integration in a way that accommodates the least restrictive approach and demonstrates that the client is socially valued.
6. The goals of the IP are based on assessed client strengths and needs and are realistic and achievable.
7. The client, their family and significant others are supported to participate in the development of the IP.
8. Clients residing in a DADHC funded or operated accommodation support service are supported to maintain their linguistic, cultural and religious ties as far as possible.
9. The cultural and language needs of the client and family will be considered when developing an IP.
10. When the family and client is from an Aboriginal or Torres Strait Islander culture the individual planning process must support the social structure of the Aboriginal and Torres Strait Islander community.
11. If a client is unable or refuses to participate in developing an IP, the Key Worker, the client's family, guardian, financial manager, case worker and other service providers develop a plan based upon the client's assessed needs.
12. When planning client goals staff must ensure that they identify the resources required and the sources of funds.

8 Explanation of terms

Client risk profile

The client risk profile is a simple, overarching and uniform risk and safety alert system designed for use throughout DADHC operated services. The system is designed to provide an easily identified risk classification system with quick reference material on individualised risk management strategies.

The client risk profile (CRP) integrates accommodation support service policies with Occupational Health and Safety responsibilities. When implemented correctly within the broader framework of client risk management, the CRP provides an effective and uniform risk alert system that remains sensitive to the individual and changing needs of a client. The CRP sits within the existing individual planning process. The client risk profile is a part of the *Client Risk Policy 2003.*

Case Management

Case management is a collaborative and individualised approach to ensure service quality, timeliness and cost effectiveness. It involves systematic assessment, planning, coordination, monitoring and evaluation of services provided to the individual client. The IP may include a range of agreed, documented and specific intervention plans.

Case Worker

A case worker is a member of the Community Support Team who has the clinical skills and knowledge to develop and conduct specific interventions to meet the needs that have been identified in the client's IP.

Complex Case Management

Complexity of service delivery to people with a disability is dependent on some critical factors. They are: the complexity of the support needs of an individual; the ability of the individual to access services; the number of services required; and the ability of the service to meet the individual's needs according to the application of the *Prioritisation and Allocation Policy and Procedures – Attachment 1 Criteria.*

Goals

Goals are client-centred statements of broad aims relating activities, skills or achievements in life arising from the client's assessed needs. These are documented and prioritised in the client's IP. There are broadly four types of goals – Lifestyle and Environment, Health, Skills Development and Social and Recreational goals. Goals may be long term or short term.

Individual plan (IP)

A document that describes the client's goals and the services or strategies to be implemented that will assist the client to meet those goals during a twelve-month period. Goals are set within available resources. The IP is reviewed every six months and modified according to the client's changing needs.

Individual planning process

The process of identifying, discussing and planning the services a client will receive the timeframe for commencement of implementation, and completion of these services. The process includes ongoing monitoring and regular reviews on the progress of agreed goals. Individual planning emphasises the participation of the client, their family and significant others in the process of identifying and agreeing upon specific goals to be achieved by the client.

Individual planning is an ongoing process.

Intervention

An intervention is a planned process, agreed to by the client, their family, guardian, advocate and/or financial manager, to assist the client to achieve goals identified in their IP. Interventions may involve modifying or changing a client's existing behaviour or action, increasing their skills, increasing their mobility or functioning, and providing specific support. An intervention is identified for each specific goal or service provided and is time limited.

Intervention plan

The intervention plan is a document that outlines the range and dimensions of the interventions that have been identified for achieving the goals in the IP. The intervention plan states the objectives and the strategies to achieve the objectives, as well as the timeframe.

Key Worker

A Key Worker is an identified staff member in the accommodation support service who is responsible for co-ordinating the development, implementation, review and documentation of an individual client's IP.

They act as a single point of contact for the client, their family or guardian and co-ordinate the range of supports that are required for their individual clients based on the documented IP.

Lifestyle and Environment Review

A Lifestyle and Environment Review aims to identify features of a client's lifestyle and environment that are particularly valued by the client as well as those features that are particularly difficult and require some action to change. The findings of the Lifestyle and

Environment Review should show priorities for assistance in maintaining a socially valued lifestyle and which parts of a client's lifestyle and/or environment have resulted in his or her reliance on challenging behaviour. This identification process leads to the development of a Lifestyle and Environment Requirement.

Lifestyle and Environment Requirement

A Lifestyle and Environment Requirement is a central feature of a well-constructed IP as it provides detailed information about how to support the client to participate as fully as possible in their daily routines and activities.

Manager

In DADHC this term refers to Network Managers, Directors of Nursing, Home Care Services Branch Managers, Managers Intake, Referral and Assessment, Managers Access, Managers Service Quality and Improvement, Managers Service System Development and Unit Managers.

Monitoring

A process or system that involves checking, supervising or overseeing a practice, situation or service to ensure that things are running as planned and to identify issues that impede smooth or planned implementation.

Referral

Involves a request for services that cannot be provided within the client's accommodation support service. Referrals can be to other DADHC services or to external service providers.

Senior Manager

In DADHC this refers to the Regional Manager, Service Development and Planning; the Regional Manager, Accommodation and Respite; Area Managers (Rural), Chief Executive Officers (Residences) and Directors (Central Office).

Service Provider

An individual or agency other than DADHC who provides a service to a client.

Strategies

The method for achieving goals, including who is responsible for implementing the strategies and the time frame in which they are expected to be implemented (what, how, who and when).

Support needs

Refers to the assistance needed by the individual to cope with the ordinary challenges of everyday living or participate in a given activity or function. It is recognised that client support needs may change, sometimes rapidly, over time across environments and across skill areas.

9 Legislation

Disability Services Act 1993

10 Forms

Attachment 1: Annual individual planning meeting form

Attachment 2: Intervention Plan form

Attachment 3: Intervention Plan Review/Final Intervention Report form

Attachment 4: Individual Plan Review Meeting form

Attachment 5: Goal suggestions from family or guardian form

Attachment 6: Annual Budget form

Attachment 7: Lifestyle and Environment Review form

Attachment 8: Lifestyle and Environment Requirements form

Attachment 9: Review of learning goals set at previous individual planning meetings form

11 Resources and guidelines

Declaration on the Rights of Mentally Retarded Persons 1983

Human Rights and Equal Opportunity Commission Act 1986 Schedule 4 & 5

Declaration on the Rights of Disabled Persons 1986

Disability Services Act 1993 and Standards

Ethnic affairs policy directions, Service Delivery to People from Diverse Cultural and Linguistic Backgrounds

Client personal finance management procedures

Intake policy

Nutrition and swallowing checklist

Client risk policy and procedures

Behaviour intervention and support policy and procedures

Prioritisation and allocation policy

Health care policy and procedures

Service planning and intervention for clients of Community Access Teams

12 Individual plan

1. An annual meeting will be held to develop each client's IP for the following year.
2. A new client will have an IP or IP review within three months of entering an accommodation support service.
3. IPs will be reviewed every six months.
4. The Key Worker is responsible for facilitating the individual planning process.

13 Prior to the annual individual planning meeting

1. A client's Key Worker, with support from the Manager, is responsible for ensuring that individual planning occurs.
2. The Key Worker discusses the individual planning process with the client using accessible communication to explain:
   - The purpose of the meeting
   - Who will attend the meeting
   - What role attendees have
   - Their wish to involve a support person or interpreter
   - Matters the client wants to contribute to the meeting or may not want discussed with all service providers/case workers
   - What assessments will be done and why
3. The Key Worker informs the client that the individual planning process includes a review of the following:
   - Health care plan including medication;
   - Epilepsy and/or asthma management plans;
   - Nutrition and swallowing checklist and plan;
   - Behaviour support plan;
   - Update of the client risk profile; and
   - Management plans.
   -
4. The Key Worker plans the meeting with the client, family, guardian and/or financial manager to maximise their participation in the individual planning meeting by:
   - Selecting an accessible, suitable meeting location.
   - Using accessible communication including arranging and utilising interpreter services if required.
   - Designing an agenda that includes opportunities for discussion and participation in decisions but remains flexible enough to allow meaningful contribution from the client at any time.
   - Ensuring all reports or assessments are communicated effectively.
5. The Key Worker chairs the meeting and identifies a minute taker. If the case is complex, the meeting is to be chaired by the Senior Manager.

6. The Key Worker ensures that others involved with the client have an opportunity to contribute to the IP including:
    - The case manager from the Community Support Team if the client has continuing service activities provided by a Community Support Team
    - Other Service Providers who are involved with the client (eg day program, employers)
    - The Key Worker forwards the family, guardian and/or financial manager a goal suggestion form (Attachment 5)
7. The Key Worker contacts (by telephone or in writing) the family, guardian and/or financial manager and any others attending the meeting to confirm the date, time and venue of the individual planning meeting.
8. If the family, guardian and/or financial manager indicate that they do not feel comfortable expressing their ideas or asking questions within the individual planning meeting, the Key Worker will encourage them to contribute their ideas in other ways such as by phone or in person prior to the individual planning meeting.
9. When applicable the Key Worker asks that all relevant reports are provided prior to the individual planning meeting including:
    - Intervention plan reviews/final intervention reports (Attachment 3) by case worker/Key Worker
    - A Needs Assessment if the last assessment is more than three years old (refer to *Prioritisation and Allocation Policy* for Needs Assessment) or equivalent functional skills assessment.
    - All health, medical and dental reviews in accordance with the health care policy and procedures including the nutrition and swallowing checklist :
    - Health care plan including medication
    - Epilepsy management plan
    - Asthma management plan
    - Nutrition and swallowing checklist and plan
    - Behaviour support plan including restricted practice authorisation
    - Client annual budget (Attachment 6).
    - A lifestyle and environment review (Attachment 7). For further information, see lifestyle and environment review below
    - Client risk profile
    - Goal suggestions (Attachment 5) from the family, guardian and/or financial manager

10. If a service provider is unable to attend the individual planning meeting the Key Worker will request that a report be provided and distributed to all who are attending the meeting.

14 Lifestyle and environment requirements and review

1. The Key Worker, in consultation with the client, their family, guardian and/or financial manager, completes a Lifestyle and Environment Requirements as per

template at Attachment 8, which considers those areas in which the client requires assistance in maintaining a socially valued lifestyle. It also identifies those parts of a client's lifestyle and/or environment that may contribute to challenging behaviours or that impact on the client's well-being.

2. The Lifestyle and Environment Review (Attachment 7), identifies issues that need to be addressed plus ideas and recommendations for actions.
3. Through the Lifestyle and Environment Requirements the Key Worker identifies those core or basic areas with which the client must have assistance or support. Commonly many of these requirements are embedded in the client's routines, but a client routine alone does not emphasise or describe the importance of the requirements to the client and their well-being.
4. This information is to be included in the client's Lifestyle and Environment Review. The extent of the information contained in the Lifestyle and Environment Requirement will differ for each client, depending on the level of support for basic daily requirements the client receives from the disability service.

15 Annual budget review

1. The Key Worker completes an Annual Budget Review with the client, their family, guardian and/or financial manager (if one has been appointed) being careful to maintain confidentiality.
2. The Key Worker includes any current budgeting, saving goals or money skills interventions or routines on the Annual Budget Review form and lists major purchases.
3. A summary of relevant financial information is provided to assist in planning the client's individual planning goals as per the Annual Budget form at Attachment 6.
4. Relevant details may be tabled at the individual planning meeting to assist in developing an Annual Budget as part of the IP. Examples of items that might be considered in the Annual Budget include:
   - Checking that the client receives all pension entitlements and benefits.
   - Making major purchases.
   - Determining that the client can afford the costs associated with identified goals.

16 During the individual planning meeting

1. The individual planning meeting is the forum for developing a written agreement between DADHC and the client, their family, guardian, advocate and/or financial manager about the support services that will be provided to meet the client's needs.
2. It is important that the client attends the individual planning meeting. If they do not wish to do so, the Key Worker ensures that the client's preferences and goals are raised in the meeting.
3. Discussion of the client and the family's goals and wishes are central to the individual planning process.
4. The Key Worker, case workers and other service providers present their reports and recommendations.

5. The Key Worker and the meeting participants draft the IP using the IP template at Attachment 1. The IP specifies the prioritised client goals and planned service activities for the following year as well as resources required and source of funds.
6. IP goals may be either long term (lifestyle goals) or short term.
7. Long-term goals may take several years to achieve, and may encompass a number of short-term goals.
8. Short-term goals are usually associated with activities that can be achieved within a 6 –12 month period.
9. There are broadly four areas of a person's life to consider when establishing goals and developing intervention plans:
    - Lifestyle and Environment Requirements
    - Skills Development
    - Health Care
    - Social and Recreational

Within these areas there are a number of sub-categories.

10. When staff of the Unit cannot provide a service activity required to meet a client goal, the Key Worker will contact other relevant providers such as the Community Support Team to discuss the appropriateness of a referral.
11. All decisions made at the individual planning meeting are to be recorded on the standardised IP and minutes kept of the meeting.
12. The client, their family, guardian, advocate and/or financial manager indicate their agreement to the draft IP by signing it.
13. Six-monthly IP review dates are determined and recorded on the draft IP.
14. The Manager endorses the IP when the services identified to meet the client's goals are within the scope of DADHC following consultation with other relevant staff.
15. Copies of the endorsed IPs are sent to:
    - The client, their family, guardian, advocate and/or financial manager
    - Relevant service providers
16. The Manager records the approval date on the Client Information System along with the IP review dates and other relevant information.

17 Implementing the Individual Plan

1. Implementing an IP involves developing and carrying out the specific intervention plans and client routines that are developed to meet the client's goals.
2. Intervention plans will be developed to achieve the goals (refer to intervention plans below). These may be developed by the Manager, Key Worker and unit staff in consultation with the client, their family, guardian and/or financial manager or they may be developed by case workers providing specialist services through the Community Support Team.
3. The Key Worker monitors the implementation of all interventions and documents the progress.
4. When IP goals are to be met through service activities provided by the Community Support Team, the Manager forwards the requests to the Manager CST for inclusion on the Service Request Register. Information to enable the

Manager CST to prioritise the requests is also forwarded (refer to prioritisation criteria).

5. When an IP goal requires referral to another service provider (other than DADHC), the Key Worker arranges the referral with the support of the Manager.
6. Once the intervention plans are in place it is the responsibility of the Key Worker to inform unit staff about the plans and monitor their implementation. If the Key Worker identifies barriers to the interventions being implemented they raise these with the Manager.
7. All unit staff are responsible for implementing the client routines and plans and completing relevant documentation.
8. The Manager supports staff to implement the clients' IPs through supervision and unit meetings.
9. The Manager ensures that all clients have current IPs and that IPs are reviewed every six months.
10. The Manager monitors the implementation of all interventions.
11. The Manager reviews the IP goals and interventions through an audit of intervention practice (including restricted practice and use of psychoactive medication).

18 Individual plan review

1. All clients who reside in Accommodation Services will have their IPs reviewed every six months from the date of the annual IP.
2. The dates for each IP review are agreed to at the annual IP meeting and recorded on the IP and the Client Information System by the Manager.
3. The Key Worker discusses the IP review with the client using accessible communication.
4. The Key Worker, in conjunction with the Manager, arranges the IP review with the client, their family, guardian and/or financial manager and other relevant participants to review the current IP goals.
5. If the IP review is to occur on a date other than the scheduled one, the Key Worker notifies those attending.
6. Three weeks before the IP review, the Key Worker checks the status of all client goals and intervention plans using the IP review meeting template at Attachment 4 as a guideline. Other status criteria to consider include:
   - Has the Key Worker developed intervention plans for activities for which they are responsible?
   - Have services requested through a CST been allocated to a case worker?
   - What evidence is there that the intervention has commenced and that staff are implementing the program?
   - Have the identified milestones been met? If not, why?
   - Does the intervention have to change? If so, how?
7. The client risk profile and the current risk management plans are reviewed by the Key Worker under the supervision of the Manager. The client risk profile is updated at the IP review to reflect any changes (refer to the *Client Risk Policy and Procedures*).

8. The client's Lifestyle and Environment Requirements (Attachment 8) are reviewed and the Key Worker documents any recommendations for changes.
9. IP reviews include participation from the client, family, guardian and/or financial manager and clinical staff. Examples of client, family, guardian and/or financial manager participation in the IP review include:
    - Attendance at the IP review.
    - Scheduled reports may be sent to the family, guardian and/or financial manager by the Key Worker for comment.
    - Phone calls with the family, guardian and/or financial manager to discuss the progress of the interventions.
10. When a new priority arises from an IP review or prior to the IP review, the Key Worker reports this to the Manager. This is considered in the IP review, and if agreed by the client, family, guardian and/or financial manager, the Key Worker revises the IP accordingly.
11. If there is disagreement between any parties working with the client, the Manager refers the matter to the Senior Manager. If the IP review indicates the need for further requests for service activities, or if existing services requests are no longer relevant, the Manager forwards this information to the Manager CST.
12. The Key Worker discusses the results of the IP review with the client.
13. The Key Worker forwards copies of the reviewed IP to:
    - The client, their family, guardian and/or financial manager
    - Relevant service providers
14. Following the IP review the Manager ensures the Client Information System is updated.

19 Intervention plans

1. An intervention plan is developed for each goal documented in the IP using the Intervention Plan form template at Attachment 2.
2. Intervention plans are developed by the Key Worker with the assistance of the Manager. Intervention plans may also be developed by other service providers when client goals cannot be met by DADHC.
3. CST staff develop, implement and review intervention plans for service activities in accordance with the *Service Planning and Interventions for Clients of Community Access Teams 2004* (pending endorsement).
4. Prior to developing an intervention plan, an assessment of the client by the Key Worker may be required. This assessment includes a review of previous interventions related to the client's goal.
5. The intervention plan sets out:
    - What the client will achieve.
    - Target behaviour or skills.
    - The roles and responsibilities of staff, family, guardian and /or financial manager.
    - Implementation location, time and frequency.
    - Resources required and source of funds needed to undertake the plan.

- Procedure for all to follow i.e. how the training will happen, teaching strategies and methods, cues to be used, communication supports, prompts and reinforcement type and schedule, behaviour strategies.
- Description of level of support the client requires to meet this goal or special considerations or arrangements relating to the implementation.
- Staff induction to intervention implementation.
- Contact details of those involved in developing the intervention implementation.
- Strategy(ies) to be used to achieve the client goals.
- The roles of other service providers where applicable.
- Timeframes for interventions and review schedule.
- Method(s) for data collection.

6. The intervention plan is written in a way that is able to be clearly and readily understood by the client, their family, guardian and/or financial manager taking into account the client's cultural and linguistic background.
7. The Key Worker provides the client, their family, guardian and/or financial manager with a copy of the intervention plan for signing. The signature of the client, family, guardian and/or financial manager indicates their agreement with the plan.
8. The Key Worker follows up with the client, their family, guardian and/or financial manager if the intervention plan has not been signed and returned within two weeks.
9. If the client, their family, guardian and/or financial manager do not agree with the intervention plan, the Key Worker discusses concerns with them and reviews the intervention plan accordingly.
10. Intervention plans developed by the Key Worker are endorsed by the Manager prior to implementation.
11. If necessary, the Manager will request or arrange skill development or training for the Key Worker and unit staff to ensure that they have the skills necessary to implement intervention plans.

20 Review of intervention plans

The Key Worker reviews each intervention plan as per Attachment 2 for the goals that they are responsible for implementing. These reviews are then considered within the context of the IP review (see above).

21 Final intervention report

1. The Key Worker prepares a final intervention report using the template at Attachment 3 when an intervention is complete.
2. The intervention is considered to be complete when any of the following occurs:

   - The objective/s have been achieved.
   - External service/s are identified that more effectively meet the client's needs and are also available.
   - The client, their family, guardian and/or financial manager choose to discontinue the service/ intervention.

- The IP review or Intervention Plan Review determines that the goal of the intervention is unsuitable or unachievable.

3. The Key Worker distributes a copy of the final Intervention Report to the family, guardian and/or financial manager.

22 Delegations

22.1 Key Worker

- Coordinates the individual planning process
- Organises individual planning meeting, and IP review meetings.
- Organises service providers meeting, if necessary.
- Assists client to participate in individual planning process as fully as possible.
- Assesses client's needs and ambitions on ongoing basis – gain agreement from family for any clinical assessments identified.
- Gathers and collate information to prepare individual planning documentation (as required in IP process).
- Ensures that the IP is written up and send to all stakeholders
- Ensures that the IP is implemented and actioned, this includes the development of intervention plans, sending appropriate referrals, monitoring the completion of Lifestyle Summary Checklist and other relevant data.
- Ensures client's profile and routine are updated to incorporate new programs/ information after individual planning meeting and IP reviews.
- Maintains record of client information and file so that history of knowledge about the client is not lost eg. update client lifestyle requirements and health history.

22.2 Manager

- Ensures that all residents have an allocated Key Worker.
- Maintains an IP and IP review for the Unit.
- Ensures ongoing implementation, monitoring and review of IP goals through supervision and at house meetings.
- Ensures there is a current household routine that documents client's IP goals.
- Endorses the IP and sends it to relevant Senior Manager after individual planning meeting.
- Provide/ support training for all staff in the individual planning process and related policies and procedures.
- Provides reports to the relevant Senior Manager on trends and issues relating to IPs. (eg. barriers to implementation, staff training needs, identify complex client issues requiring clinical support) and maintains a register documenting these issues.
- Monitors implementation of the IPs through supervision.
- Monitors IP timeframes and ensures all clients have current IPs.
- Monitors the implementation of behaviour intervention plans and use of psychoactive medications
- Monitors the client risk profiles and implementation of client risk management plans,

- Endorses the IP,

22.3 Senior Manager

- Monitors IPs and checks client risk profiles, health care interventions and behaviour interventions (Restricted Practice Authorisations).
- Chairs the individual planning meeting, if the case is complex.

Abuse and Neglect
Policy and procedures

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TABLE OF CONTENTS

GLOSSARY

Abuse
Abuse as it is used throughout this policy refers to sexual assault, physical, emotional, financial and systemic abuse, domestic violence, constraints and restrictive practices, and to neglect.

Action plan
A plan developed by a manager that describes strategies to identify and assess risks, and the process employed to eliminate or manage risk. Measures include:
- Reviewing the practice used prior to and during the incident in line with the unit and client routines, and with reference to client management plans;
- Reviewing client management plans to prevent further incidents or to minimise their effects on clients' lifestyle and wellbeing;
- Applying a risk management approach to work practices (DADHC staff can refer to the *OHS Risk Management Policy, 2004)*.

Advocate
A person who promotes, supports and represents the rights and interests of another person. An advocate is often involved in acting, speaking or responding on behalf of another person. Staff cannot be advocates for people with a disability who are clients of DADHC operated or funded non-government services.

Assault
Assault, as described in the *Crimes Act 1900,* is against the law. For the purpose of this policy assault is any attempt or threatened attempt to cause unwanted immediate physical contact or bodily harm that puts the victim in fear of such harm or contact.

Client
The client is a person with a disability who lives or participates in a DADHC operated or funded non-government service.

Client Risk Profile
The *Client Risk Profile* is a simple risk assessment tool for staff working directly with clients. It is used to characterise risks by providing quick reference material for individualised risk management strategies. It is designed for use throughout DADHC operated and funded non-government services.

The *Client Risk Profile* integrates DADHC policies with Occupational Health and Safety responsibilities. When implemented correctly, within the broader framework of client risk management, the *Client Risk Profile* provides an effective and uniform risk alert system that remains sensitive to the individual and changing needs of a client. The *Client Risk Profile* sits within the existing *Individual Planning* process.

Duty of care
The requirement a disability service has to take reasonable care to avoid foreseeable harm to a client.

Guardian[1]
A substitute decision-maker with authority to make personal or lifestyle decisions about the person under guardianship. A guardian is appointed for a specified period

[1] Guardianship Tribunal at http://www.gt.nsw.gov.au/questions/definitions.cfm

of time and is given specific functions (e.g. where the person lives, or services and medical treatment the person receives). A guardian may be appointed who is a family member or friend provided the criteria set out in the legislation are satisfied. Otherwise, the Guardianship Tribunal will appoint the Public Guardian.

Manager or line manager
For reporting purposes in this policy the manager or line manager is the next person in line to receive a report of abuse or to take action on an allegation of abuse.

Person responsible[2]
Someone who has the authority to consent to treatment for an adult who is unable to give a valid consent to their own medical or dental treatment. Sometimes, a person is unable to make the decision or does not understand what the treatment is about or its effects. In these cases, the person responsible can give substitute consent on behalf of the other person.

A 'person responsible', in order of hierarchy, is:
1. a guardian (including an enduring guardian) who has the function of consenting to medical, dental and health care treatments or, if there is no guardian,
2. the most recent spouse or de facto spouse (including same sex partner) with whom the person has a close, continuing relationship or, if there is no spouse or de facto spouse,
3. an unpaid carer who is now providing care to the person or arranged/provided this support before the person entered residential care or, if there is no carer,
4. a relative or friend who has a close personal relationship with the person.

Support person
In the context of this policy, a client who has been abused may be required to talk to the police, a sexual assault worker or representative of a legal or victim's service, and will need support at these times. The support person does not have the same function as the 'person responsible' and will not make decisions for the client. The person may be a member of staff who is known and trusted by the client. The support person may also be from an advocacy service.

[2] Guardianship Tribunal at http://www.gt.nsw.gov.au/information/doc_14_substitute_consent.htm

1 POLICY

1.1 Background

The provisions of the *NSW Disability Services Act 1993* and supporting Standards clearly outline the obligations that service providers have to ensure the rights of people with a disability are met as equal members of society.

Those rights include their entitlement to feel safe, and to live in an environment where they are protected from assault, neglect, exploitation or any other form of abuse. Studies on the frequency of abuse towards people with a disability show that they are much more likely to experience abuse than the rest of the population (Howe, 2000; Blyth, 2002)[3]. A range of factors contribute to the higher levels of abuse experienced by people with a disability, for example, low mobility, limited communication skills, high dependence on non-family members for personal care, and the use of shared accommodation services.

1.2 Preventing abuse

The Department of Ageing Disability and Home Care acknowledges that prevention is the best protection from abuse. Service providers have a duty of care to implement prevention strategies that include suitable recruitment screening processes and protocols for identifying the risk indicators for abuse. Prevention strategies should provide for the employment of skilled staff who respect the rights of clients, who are aware of current policies and legislation pertaining to abuse, and who will support clients and their families or guardians to access complaint mechanisms and raise any concerns they have about services.

Refer to Appendix 1 for a summary guide to the prevention of abuse and early intervention strategies.

1.3 Purpose

If for any reason prevention strategies fail to afford protection, the *Abuse and Neglect Policy* aims to provide paid or unpaid workers of DADHC operated and funded services, with the means to respond quickly and appropriately to allegations of abuse.

1.4 Target group

All paid and unpaid workers in DADHC operated and funded non-government services who have contact with adult people with a disability.

1.4.1 The clients

A client is any adult person with a disability who lives or participates in a DADHC operated or funded non-government service. The disability may make it difficult for the person to move independently, communicate or perform activities of daily living,

[3] In *Violence against women with disabilities – An overview of the literature,* Keran Howe, 2000. Women With Disabilities Australia (WWDA).
Myalla. Responding to people with intellectual disabilities who have been sexually assaulted. Northern Sydney Health Sexual Assault Service, 2002.

without assistance. The disability can be the result of an intellectual or physical impairment, or of an acquired injury.

The abuse or neglect of a child (0-15 years) or a young person (16-18 years) must be reported immediately to the Department of Community Services (DoCS) Helpline on 132 111. The DADHC *Child protection policy and reporting procedures for DADHC and DADHC-funded services*, 2004, describes the circumstances and procedures that staff must be aware of in relation to the abuse or neglect of children and young people.

1.4.2 The services

The organisational structure of a service will determine the reporting procedures that are followed in response to an allegation of abuse.

The following DADHC operated services have designated reporting lines in accordance with the organisation's structure that must be adhered to following an allegation of abuse:

- Accommodation support services (in-home support, group homes and large residential centres);
- Respite services;
- Community Access programs, including day programs and community participation; and
- Community Support Teams.

Organisations that provide the following DADHC funded non-government services are required under Standard 10 (*Standards in Action*) to have reporting procedures in place that must be followed on receiving an allegation of abuse:

- Accommodation support services (in-home support, group homes and large residential centres);
- Flexible and centre based respite services; and
- Community programs, including Transition to Work, therapy and day programs.

1.5 Advocacy and client support

Clients of DADHC operated and funded non-government services have different types of support networks. Clients have families who are closely involved in their lives or may be reliant on legally appointed guardians to make particular decisions for them. Other clients are represented by advocacy services and for some clients these advocates are their only support network.

An advocate must represent the best interests of a client, and in the absence of a family member or any other person having a close relationship with the client, may be the contact person for issues relating to the client. Other clients may be the passive recipients of informal advocacy support, and in this case, service providers will have to consider what information about a client is appropriate for sharing with an informal advocate.

The issue of information sharing arises in the *Abuse and Neglect Policy* and a balance is required between:

- ensuring that people who have an important relationship with the client are informed when there is an allegation of abuse involving that client, and
- obeying the law as it applies to upholding individuals' rights to privacy.

1.6 Types of abuse addressed in this policy

Abuse is used throughout the policy to describe behaviour or actions that are intended to cause harm to a person with a disability. The types of abuse referred to in this policy are defined below. (Examples of each are provided in **Appendix 2**).

1.6.1 Domestic violence

Violence, abuse and intimidation perpetrated by one person against another in a personal, intimate relationship. Domestic violence occurs between two people where one has power over the other causing fear, physical and/or psychological harm.

1.6.2 Neglect

Neglect is a failure to provide the basic physical and emotional necessities of life. It can be wilful denial of medication, dental or medical care, therapeutic devices or other physical assistance to a person who requires it because of age, health or disability. It can also be a failure to provide adequate shelter, clothing, food, protection, supervision and nurturance or stimulation needed for social, intellectual and emotional growth or well being. It can be the placement of persons at undue risk through unsafe environments or practices thereby exposing them to the danger of physical, mental or emotional harm.

1.6.3 Physical abuse

Physical abuse is assault, non-accidental injury or physical harm to a person by any other person. It includes but is not limited to inflicting pain or any unpleasant sensation, and causing harm or injuries.

1.6.4 Restraints and restricted practices

Restraining or isolating an adult for reasons other than medical necessity or in the absence of a less restrictive alternative to prevent self-harm. This may include the use of chemical or physical means or the denial of basic human rights or choices. These practices are not considered to be abuse if they are applied under a restricted practice authorisation.

1.6.5 Sexual assault

It includes any sexual contact between an adult and child 16 years of age and younger. Any non-consensual sexual activity with an adult who is threatened, coerced or forced to engage in sexual behaviour is sexual assault. It includes language or exploitative behaviour and can take the form of rape, indecent assault, sexual harassment or sexual interference in any form.

1.6.6 Emotional abuse

Includes verbal assaults, threats of maltreatment, harassment, humiliation or intimidation, or failure to interact with a person or to acknowledge that person's existence. This may also include denying cultural or religious needs and preferences.

1.6.7 Financial abuse[4]

The improper use of another person's property or assets, or the use or withholding of another person's resources by someone with whom there is a relationship implying trust.

1.6.8 Systems abuse[5]

In its simplest form, systems abuse occurs when the needs of people with a disability who are in receipt of a service are not recognised, and essential services are not provided or are inadequate, inappropriate or poorly coordinated. The impact on individuals can include neglect or abuse resulting from poor practice, exclusion from community life and the loss of basic human rights.

Other terms used in this policy are defined in the Glossary at the beginning of the document.

1.7 Legislative context

Community Services (Complaints, Reviews and Monitoring) Act 1993
"An Act to provide for complaints, reviews and monitoring in relation to the provision of community services; to provide for Official Community Visitors and their functions; to confer and impose functions on the Ombudsman, to confer and impose functions on the Administrative Decisions Tribunal; and for other purposes".

NSW Crimes (Forensic Procedures) Act 2000
"An Act to make provision with respect to the powers to carry out forensic procedures on certain persons and to make provision with respect to a DNA database system; to make a related amendment to the *Justices Act 1902* and consequential amendments to the *Crimes Act 1900*; and for other purposes".

Criminal Procedures Act 1986
"An Act relating to the prosecution of indictable offences, the listing of committal proceedings and proceedings for summary offences and the giving of certain indemnities and undertakings; and for other purposes".

Independent Commission Against Corruption Act 1988
"An Act to constitute the Independent Commission Against Corruption and to define its functions. The principal objects of this Act are:

(a) to promote the integrity and accountability of public administration by constituting an Independent Commission Against Corruption as an independent and accountable body,

[4] From *Policy framework for the care and protection of vulnerable people with disabilities,* Disability Services Commission, Western Australia, 2005.
[5] From *Abuse Prevention Strategies in Specialist Disability Services,* NDA 2002.

(b) to investigate, expose and prevent corruption involving or affecting public authorities and public officials,

(c) to educate public authorities, public officials and members of the public about corruption and its detrimental effects on public administration and on the community, and

(d) to confer on the Commission special powers to inquire into allegations of corruption."

NSW Crimes Act 1900 and Section 316
The section relates to "concealing serious indictable offence".

Law Enforcement (Powers and Responsibilities) Act, 2002
"An Act to consolidate and restate the law relating to police and other law enforcement officers' powers and responsibilities; to set out the safeguards applicable in respect of persons being investigated for offences; to repeal certain Acts and to consequentially amend other Acts; and for other purposes".

NSW Disability Services Act 1993 and supporting Standards
"An Act relating to the provision of disability services for persons with disabilities".

The Home Care Service Act, 1988
"An Act relating to the constitution of the Home Care Service of New South Wales".

Mental Health (Criminal Procedure) Act, 1990
"An Act with respect to criminal proceedings involving persons affected by mental illness and other mental conditions".

Privacy and Personal Information Protection Act, 1998
An Act to provide for the protection of personal information, and for the protection of the privacy of individuals generally; to provide for the appointment of a Privacy Commissioner; to repeal the *Privacy Committee Act 1975*; and for other purposes.

Protected Disclosures Act, 1994
An Act to provide protection for public officials disclosing corrupt conduct, maladministration and waste in the public sector; and for related purposes.

Victims Rights Act 1996
"An Act to establish a charter of rights for victims of crime; to amend the *Criminal Procedure Act 1986* with respect to victim impact statements; and for other purposes".

Victims Support and Rehabilitation Act, 1996
"An Act to provide support and rehabilitation for victims of violence; and to repeal the *Victims Compensation Act 1987"*.

United Nations Rights of the Disabled Person 1975

2 PRINCIPLES

The following Principles are to be observed by all DADHC operated and funded non-government services in response to an allegation of adult client abuse.

DADHC funded non-government services must ensure that the intent of the Principles is reflected in their operational procedures.

2.1 Preventing abuse

Service providers take reasonable steps to ensure that all paid and unpaid workers understand and perform their roles in preventing abuse of clients by any person. **Appendix 1** provides some prevention strategies that may be employed by service providers.

2.2 Identifying abuse

Paid and unpaid employees working with people with a disability understand the behaviours or actions that constitute abuse. **Appendix 2** describes eight types of abuse, and examples of behaviours that on their own or together could be abusive.

Paid and unpaid employees working with people with a disability are able to recognise signs that may be indicators of abuse. **Appendix 3** describes the behaviours and physical signs that a client may show in response to abuse.

Service providers recognise that people with challenging behaviour, and people who are non-verbal or who experience communication difficulties, may be more vulnerable to abuse.

2.3 Reporting abuse

The procedures for reporting allegations or suspicions of client abuse are clearly articulated and include the responsibilities of all parties involved in the process.

The culture of the organisation or service will encourage and support any person who has witnessed abuse of a client or clients, or suspects that abuse has occurred, to make a report of abuse and be confident of doing so without fear of retaliation and in a supportive environment.

All paid and unpaid workers are aware of their responsibility to report allegations of abuse in accordance with the service provider's documented procedures. **Appendix 1** contains strategies for ensuring that staff are aware of their responsibilities towards clients.

2.4 Responding to a report of abuse

Response is prompt, appropriate and in accordance with clearly documented procedures. The response should include appropriate reporting to the NSW Police, and the provision of medical care, including transfer to hospital by an ambulance and referral to a Sexual Assault Service if the assault is of a sexual nature.

When the victim is unable to give consent, the family, guardian or other support person are notified of the incident as soon as possible.

If it is appropriate and the victim has given consent, the family or guardian of the victim, or other support person, are informed of the allegation of abuse as soon as possible after the report is made.

All aspects of the incident are documented in accurate written accounts, including any follow up actions.

2.5 Responding to abuse of a client by a member of staff

All incidents and allegations of abuse are documented and reported to a manager.

All reasonable steps are taken to ensure that the client is protected from further harm by preventing contact with the alleged offender.

The rights of the worker and responsibilities of the employer are adhered to in accordance with the appropriate legislation.

2.6 Responding to abuse of a client by another client

Services manage the interactions between clients to avoid incidents of abuse, and record in behaviour management plans the triggers that may cause one client to harm another.

If behaviour management strategies fail to prevent the abuse of one client by another, clients are protected from further harm.

A review of the circumstances pertaining to the event is conducted within a reasonable timeframe.

Any behaviour management strategies implemented by the service are safe, respectful of the person and non-abusive.

When the victim and offender are both clients they are equally entitled to support during the response process by an independent person.

2.7 Privacy and confidentiality

Access to records is restricted to those who are directly involved in reporting and responding to the incident to ensure that individuals' rights to privacy are upheld.

A key staff member is appointed to be the sole contact for the family, guardian or other support person in providing information relating to the incident and any subsequent investigations.

2.8 Responsibilities

The service's response process does not compromise any investigation by the NSW Police or other external agencies.

Staff and witnesses cooperate with the investigations of NSW Police and other agencies as required.

Clients are assisted by an independent support person during their contact with the NSW Police and other agencies.

The roles and responsibilities of management, staff and volunteers in responding to a report or allegation of abuse are documented and clearly defined.

3 REPORTING ABUSE TO NSW POLICE

3.1 EMERGENCY – DIAL 000

When a client or another person has been assaulted or is in immediate danger of an assault the **NSW Police** must be called (see **3.3** below for exceptions).

If a client or another person sustains an injury as the result of an assault the **NSW Ambulance Service** must be called.

3.2 Reporting to NSW Police

3.2.1 Sexual assault

Sexual assault of a client is a serious offence and must be reported to the NSW Police (see **3.3** below for exceptions).

3.2.2 Physical assault

Any other physical assault of a client must be reported to the NSW Police (see **3.3** below for exceptions).

3.2.3 Other assault

A report of **domestic violence,** or **abuse** by **neglect** and **restricted practices,** and **emotional**, **financial** and **systems abuse**, must be reported to a manager as soon as possible and may be reported to the NSW Police.

3.3 Exceptions

A report to the NSW Police about an assault may **not** be required if any of the following conditions exist:

- an incident that would usually be classed as assault, is caused by a person with an intellectual disability who lacks understanding of the behaviour; and
- physical contacts occurring between clients (e.g. pushing or striking) that are appropriate for resolution using behaviour management strategies, and are reported internally.

If in doubt about reporting abuse the NSW Police may be contacted for advice.

4 RESPONSE PROCEDURES FOR DADHC OPERATED SERVICES

A report of abuse may be received from:

- **a person with a disability** using verbal or written communication or any other communication system;
- **another client**, **member of staff** or any other person, who may witness abuse of a client and make a report; or
- **a member of staff** upon observing one or more indicators of abuse (**Appendix 3**) suspects that a client or clients have been or are being abused.

The following procedures must be followed where abuse of any sort towards a client is known or suspected. To assist staff, the procedures described below for responding to sexual and physical assault, and abuse or neglect, are also depicted in flow charts (Flow charts 1, 2 and 3 following this section). The one-page flow charts may be copied and displayed where staff can access them quickly and easily if necessary.

4.1 Emergency response

4.1.1 Staff who are present at the time of an assault should take appropriate measures to maintain their own safety, and that of other clients and staff.

4.1.2 Staff at the scene must ensure that the client (the victim) is protected from any further harm or contact with the person who is the source of abuse (the offender).

4.1.3 Staff at the scene must notify the doctor or ambulance if the client or any other person is injured.

4.1.4 Staff at the scene must **immediately** advise the line manager, or 'on call' line manager of the incident.

4.1.5 Staff at the scene or the line manager must contact the NSW Police if a client has been physically or sexually assaulted (**Section 3**) or dies as the result of an assault.

4.1.6 Staff at the scene or the line manager must also contact the local Sexual Assault Service if a client has been sexually assaulted (**Appendix 4**).

4.2 Protecting evidence for NSW Police

4.2.1 Staff at the scene must use their best endeavours to ensure that any evidence the NSW Police may require in their investigation is not disturbed.

4.2.2 Evidence may be lost if a victim of sexual assault bathes soon after the assault. Try and delay bathing until the NSW Police arrive if the victim is not distressed by the delay.

4.2.3 If possible, preserve the victim's clothing as evidence following an assault of any type.

4.2.4 If possible, isolate the area where the incident occurred and do not allow anyone to enter the area until the NSW Police arrive.

4.2.5 Apart from ascertaining their physical condition and state of mind, avoid questioning clients about the incident to reduce contamination of their recall and confusion about the events.

4.3 The line manager's role

4.3.1 The line manager should ensure that all emergency procedures have been followed and the appropriate emergency services have been called.

4.3.2 The line manager must ensure that the victim's wishes are followed in relation to advising family, guardian or other support person about the incident, where the victim is capable of making this known. When the victim is not capable then the line manager should make sure the appropriate person is notified of the incident **as soon as possible** and **within 12 hours** of the report being made.

4.3.3 The line manager is responsible for ensuring that documentation of the incident is completed and reports are forwarded to the appropriate levels of management.

4.4 Abuse by a member of staff

4.4.1 If it is witnessed or suspected that a member of staff has abused a client or clients, the line manager or 'on call' line manager must be informed **immediately**.

4.4.2 If it is suspected that the line manager is involved in the abuse the matter must be reported to the next level manager **immediately**.

4.4.3 Where management reasonably believes that a member of staff is the source of abuse of a client the matter must be referred to the NSW Police.

4.4.4 Each DADHC Region is responsible for adopting a protocol for making referrals to the NSW Police and for managing the referral process locally.

4.4.5 Any cases of suspected abuse by a member of staff must be reported to the DADHC Ethics and Professional Standards Unit (EPSU)[6].

4.4.6 The EPSU will offer advice and assistance to the Region in the management of this matter.

4.4.7 A member of staff who is reasonably suspected of abusing a client must not be permitted to have any unsupervised contact with the client, and may be immediately transferred to alternative duties following the allegation and until the matter is resolved.

4.4.8 Any allegations of abuse by a member of staff towards a client will be the subject of internal investigations within DADHC, and by the NSW Police.

4.4.9 If it is found that a member of staff has abused a client, the matter may warrant dismissal of the staff member by DADHC, as well as any action taken by the NSW Police.

4.4.10 If a staff member accompanies the offender who is another staff member to the police station to provide support, the staff member must not give an opinion about the offender or the alleged incident or give the offender legal advice. The staff member should be replaced by an independent support person or a legal adviser as soon as possible.

4.5 Abuse by another client

4.5.1 When one client is the suspected or known source of abuse towards another client, staff must ensure that the rights of both clients are observed during the response and reporting processes.

4.5.2 Any decisions made in relation to managing the incident must be fully documented for future reference, along with the reason for the decision and the name and contact details of the person making the decision.

4.5.3 The line manager must ensure that the wishes of the victim and the offender are followed in relation to advising family, guardian or other support person about the incident, where they are capable of making this known. When the victim and/or the offender are not capable then the line manager will notify the appropriate person of the incident **as soon as possible** and **within 12 hours** of the report being made.

4.5.4 The manager will facilitate access to appropriate support, where practical, for both clients, their families and staff, and ensure they have information about available services (**Appendix 4**).

[6] If the employee is a permanent officer the matter will be dealt with by the EPSU under the Procedural Guidelines (s 44) of the *Public Sector Employment and Management Act, 2002*. If the employee is a causal or temporary officer or a permanent, temporary or casual employee under the *Home Care Service Act, 1988* the process will be managed pursuant to the DADHC Policy *Guidelines for Managing Allegations of Misconduct, 2006.*

4.5.5 If a manager reasonably believes that an incident between two clients is abuse or assault the matter must be referred to the NSW Police.

4.5.6 If a staff member accompanies the offender who is a client to the police station to provide support, the staff member must not give an opinion about the offender or the alleged incident, give the offender legal advice, question the offender on behalf of the police or interpret the offender's answers. The staff member should be replaced by an independent support person or a legal adviser as soon as possible (**Appendix 4**).

4.6 Financial abuse

4.6.1 Staff of DADHC operated services must follow procedures described in the policies, Managing Clients' Personal Finances in DADHC Residences, updated June 2006 and Principles for the Management of Finances in Residences, Accommodation and Centre-Based Respite Services, updated June 2006, when administering clients' personal finances.

4.6.2 Where clients are vulnerable, and unable to manage their personal finances, this may be done informally by the family, guardian or other support person. In the absence of a suitable informal financial manager, application is made to the Guardianship Tribunal to appoint a formal financial manager.

4.6.3 Staff of DADHC operated services are required to comply with the Department's reporting processes (4.14 Regional reporting) if they suspect irregularities in the management of clients' personal finances.

4.6.4 When there is an allegation of financial abuse, the manager must notify the client, family or guardian, and/or the administrator of the client's finances. The matter may be reported to the NSW Police (see Section 3).

4.7 Past incidents of abuse

4.7.1 If the abuse has happened in the past, and the client is not in immediate danger, the line manager must be notified as soon as possible.

4.7.2 If the line manager reasonably believes that abuse has occurred, or is in any doubt, the matter must be referred to the NSW Police for further investigation.

4.8 Communication

4.8.1 The line manager should appoint a contact person to communicate with the victim and family, guardian or other support person to ensure that information relating to the incident is provided through one coordinated source.

4.8.2 Information being relayed to the victim must be provided in a form that is understandable, and this includes ensuring that a support person is available who knows the victim's communication requirements.

4.8.3 When the victim is unable to make decisions about any aspect of the incident, a family member or guardian must be present to make decisions on the victim's behalf. Where this relates to medical treatment or forensic

examination consent must be provided by a person responsible in accordance with the *Guardianship Act.*

4.9 Support for clients

4.9.1 The victim and family, guardian or other support person should be assisted to access any debriefing, counselling, legal or other support services if that is their wish.

4.9.2 Clients who are victims of abuse and their families or guardians should be referred to Victims Services NSW on **1800 633 063** to be advised of their rights, and the support services that are available to them (**Appendix 4**).

4.9.3 Managers will facilitate access for victims of violent crimes and their families who may be eligible to apply for counselling with the Approved Counselling Service provided by Victims Services NSW.

4.9.4 Staff must ensure that clients, both victim and offender, are adequately supported by an independent person, who could be a relative, friend, advocacy service or legal practitioner.

4.9.5 The victim, family, guardian or other support person will have the choice of pursuing the matter through the legal system and must be supported to access the services and advice they require. **Appendix 4** contains a list of organisations that provide legal advice and services.

4.9.6 Information provided to a client, guardian or other support person about legal rights, options and support services, must be provided in a format that suits their individual communication needs.

4.10 Support for staff

4.10.1 Staff should be offered a debriefing session within 24 hours of the incident occurring[7].

4.11 Privacy and confidentiality

4.11.1 All staff members who are in contact with the victim or the offender will maintain confidentiality of information between the individuals who are directly involved in responding to the incident.

4.11.2 Confidentiality must be maintained when making a report to external agencies. Failure to do so may prejudice any subsequent investigation and cause unnecessary hurt or embarrassment to individuals.

[7] *Serious Incident EAP Support Request Form*

4.12 Record keeping

4.12.1 It is imperative that comprehensive and accurate documentation is maintained in the interests of all parties, and to ensure accountability and transparency in decision-making.

4.12.2 A detailed written report should be completed as soon as possible to ensure it is an accurate record of the incident. The report should include:

- the nature and extent of the incident and an Incident Reporting Category[8] for the CIS;
- a description of the incident completed as soon after the event as possible and being an exact record of the events;
- additional reports written by other witnesses or persons present at the time the incident occurred;
- the name and contact details of all those involved, particularly in relation to decisions that are made as a result of the incident;
- the response provided to the person making the allegation;
- the date and signature of the person making the report;
- ongoing actions required to resolve the matter; and
- the outcome, although, depending on the nature of the incident an outcome may be delayed.

4.12.3 Records are maintained to comply with the standards published under the authority of the *State Records Act 1998* that also requires records of disciplinary proceedings in relation to employees be retained indefinitely.

4.12.4 Staff of DADHC Accommodation and Respite services should refer to the *Record Management Procedures for DADHC Group Homes 2006*.

4.12.5 Records must be stored securely and only accessed by persons with a legitimate reason for viewing any documents.

4.13 Managing risk

4.13.1 The line manager and staff must assess the risk of further incidents and update any risk management plans pertaining to the event and the clients involved.

4.13.2 The line manager and staff must review the *Client Risk Profile*[9] of any clients involved in the incident to assess and manage the risk of further incidents of abuse.

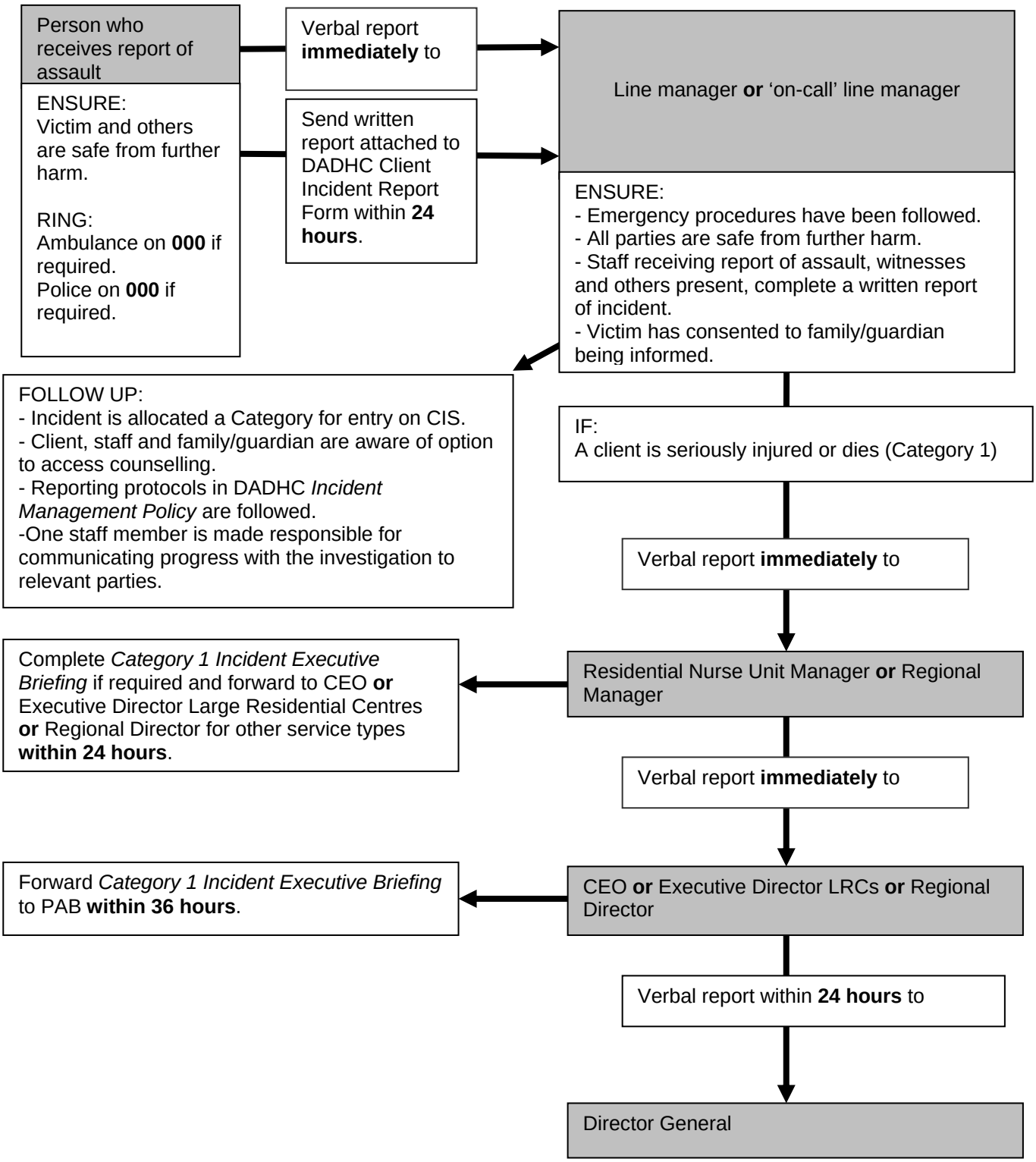
4.14 Regional reporting

4.14.1 The Regional Manager will follow the incident reporting requirements of the DADHC *Incident Management Policy*, 2006 (Sections 7 & 8).

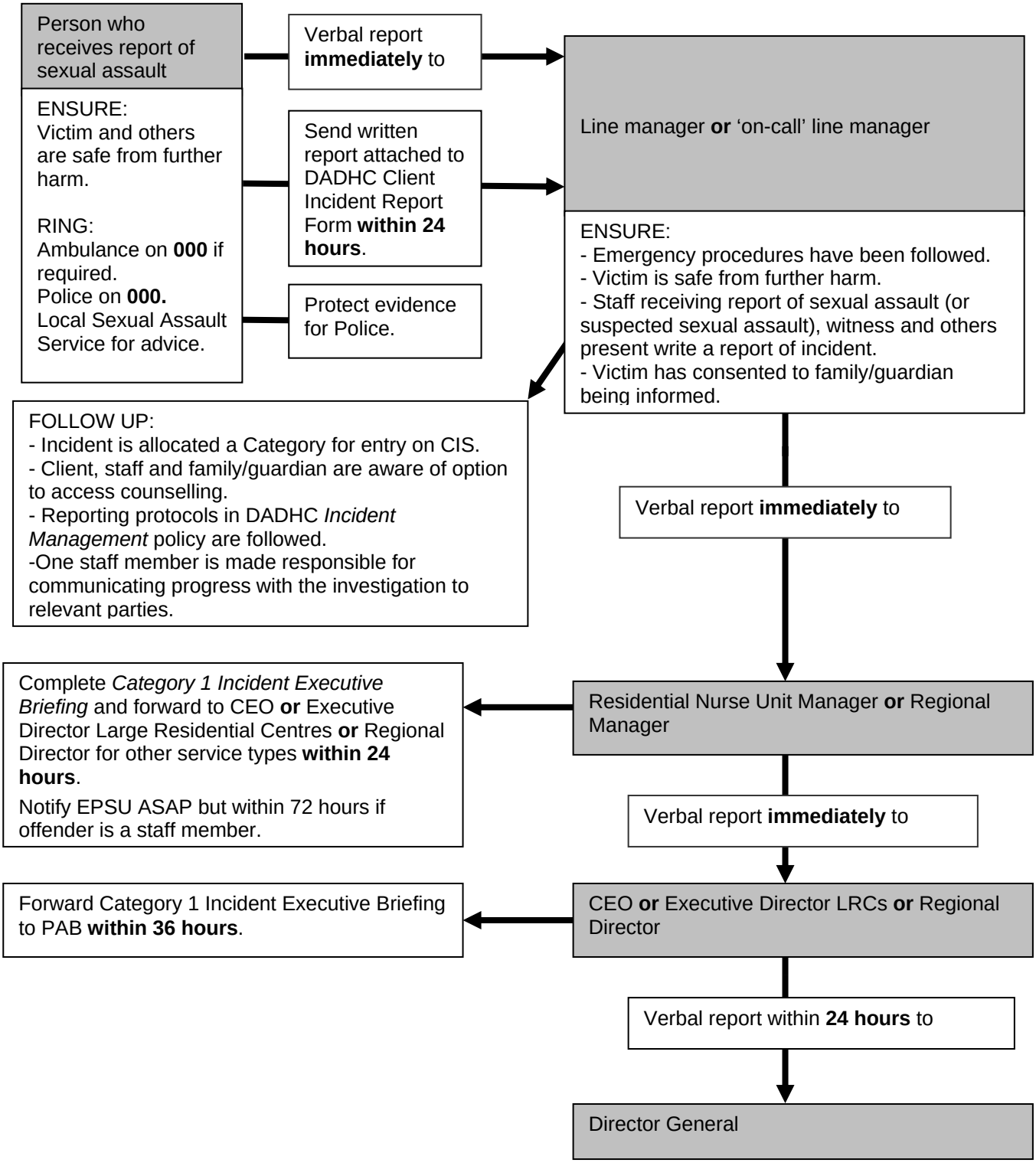
4.14.2 A report of the death of a client should be provided in accordance with the 2004 DADHC policy *Response to the death of a client and reporting reviewable deaths*.

[8] Refer to DADHC *Incident Management Policy*, 2006, Appendix A, for a guide to Incident Reporting Categories.
[9] DADHC *Managing Client Risks* policy

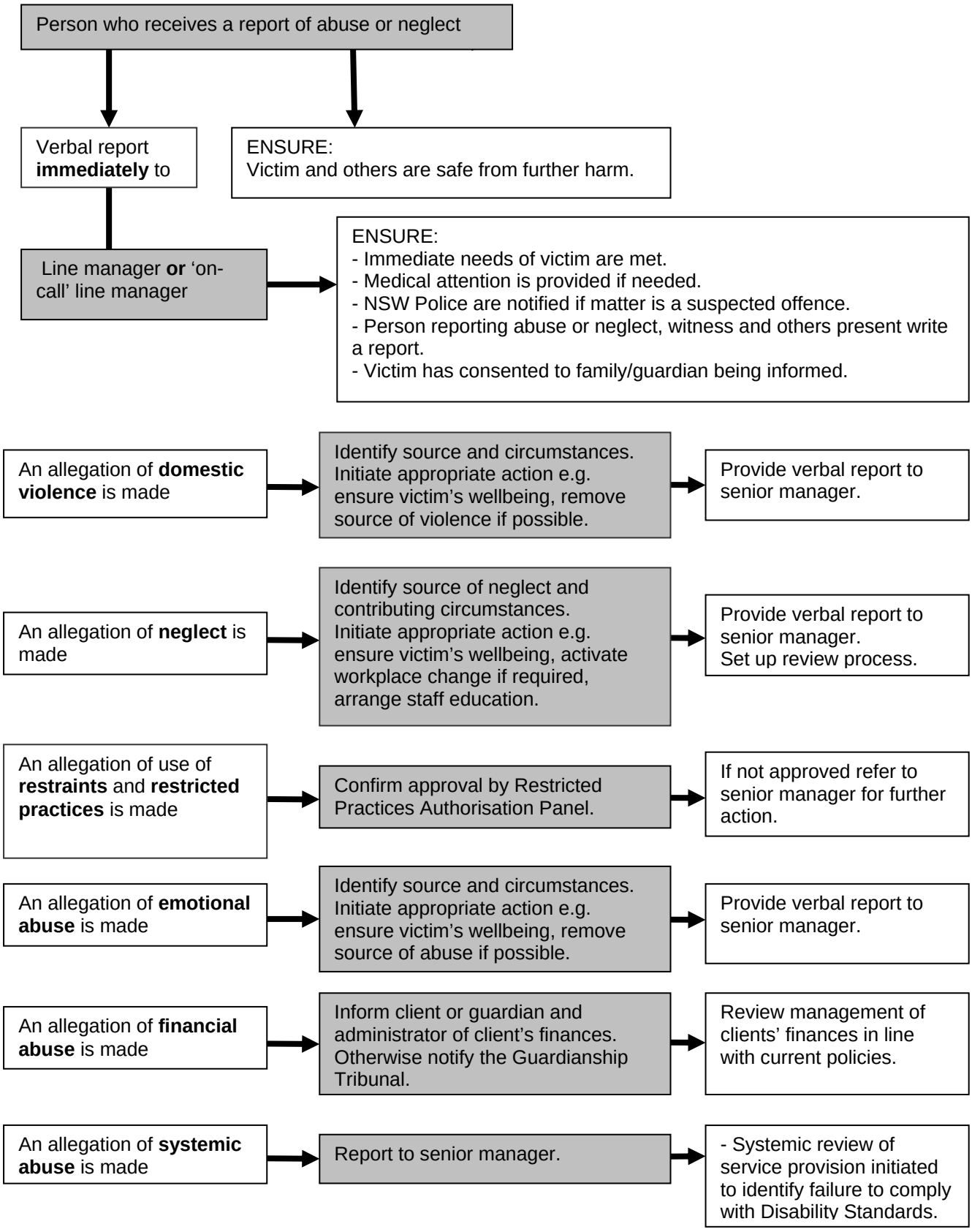
FLOW CHART 1. Response to **physical assault** or an allegation of physical assault towards an adult client (18yrs and over).



FLOW CHART 2. Response to **sexual assault** or an allegation of sexual assault towards an adult client (18yrs and over).



FLOW CHART 3. Response to abuse or neglect or an allegation of abuse or neglect towards an **adult** client (18yrs and over).



5 APPENDICES

5.1 PREVENTION AND EARLY INTERVENTION

Effective **prevention strategies** will include recruitment screening processes to protect clients from exposure to individuals who have a history of harming vulnerable people. By ensuring that new recruits are adequately screened services can maximise their chances of employing suitable individuals to work with people with a disability.

Prevention strategies that relate to good practice in recruitment and retention are summarised below.

Position descriptions	Avoid ambiguous statements. Include clear expectations regarding behaviour towards clients.
Selection process	Conduct structured interviews. Develop specific questions to explore applicants' attitudes to the abuse of clients.
References	Check references provided by applicants.
Criminal record checks	Request a check from an appropriate source. Advise applicant that a criminal record check will be made.
Induction	Provide a code of conduct for new staff to read and sign. Include clear statements about behaviour towards clients. Include responding to abuse in initial training sessions. Provide full briefing to agency staff about the organisation's policies on abuse before they commence work with clients.
Staff training	Keep staff well informed about inappropriate treatment of clients. Discuss client issues clearly and openly, for example sexuality and consent. Review code of conduct.
Staff responsibilities	Remind staff that any observation or suspicion of abuse must be reported to a manager or supervisor. Remind staff to respect the rights of clients, families, other staff and the organisation.
Management responsibilities	Manage staff performance. Provide strong leadership and examples of respect for others.

In the same way that effective recruitment screening practices aid in reducing clients' exposure to harm, the provision of orientation sessions for workers to identify the risk indicators for abuse will increase their ability to recognise the early signs of possible abuse (**Appendix 3**).

Workers need to know the issues associated with abuse of people with a disability, including assault and neglect, and must be aware of current policies, procedures and legislation pertaining to abuse and individual rights.

Clients and staff should be educated to understand the rights of clients, their sexuality and human relationships, and their need to learn self-protective behaviours to the best of their abilities.

A consideration for staff could be the introduction of self-protective behaviours such as the development of 'intimate care plans' detailing the level of personal contact between a client and worker that is required for the adequate provision of care, and that is understood by the client and the worker.

Protection of clients and prevention of harm will be enhanced by fostering an organisational culture that actively encourages and supports clients, and their families or guardians, to access complaint mechanisms and raise concerns about service delivery. This includes ensuring that all clients have the opportunity to express their needs positively and to have some control and choice in their lives.

Intervention strategies for workers include a range of approaches that are summarised in the following table.

Awareness and identification	Recognising a possible risk of abuse and referring to appropriate agencies or senior management for assessment.
Risk assessment	Assess the situation to determine the presence, nature and extent of abuse. If it is appropriate, involve other agents in a resolution, for example, general practitioners, social workers or community workers.
Case coordination	Assess and arrange appropriate services for clients who are at risk or are victims of abuse.
Support services	Provide health, welfare, counselling and victims support, or other appropriate services.
Legal intervention	Access appropriate legal services (**Appendix 4**).

5.2 TYPES OF ABUSE

Observed abuse
Workers in accommodation services, or any other services used by clients, are most likely to observe incidents of abuse towards clients.

Reported abuse
Abuse may be reported directly to staff by the victim or by another client who has observed the incident or multiple incidents. A direct care worker or any other person, may observe the abuse of a client or clients, and report it to a responsible person.

Suspected abuse
A direct care worker or any other person may detect unusual behaviours or events that could be indicators of client abuse. Another carer, a family member or a guardian who knows a client well and has reason to suspect that the client is being abused should inform a responsible person among the direct care staff. Any other person who is not necessarily familiar with a client but suspects that there is an abusive situation should also report any suspicion of abuse to a senior member of staff who knows or is involved in the client's circle of support.

5.2.1 Types of abuse

The following definitions[10] of abuse are taken from known sources. Abuse is not limited to the types defined below and employees are required to consider that any inappropriate behaviour towards a client may be abuse.

5.2.1.1 Domestic violence

Violence, abuse and intimidation perpetrated by one person against another in a personal, intimate relationship. It is a partnership violence that includes violence perpetrated when couples are separated or divorced. Domestic violence occurs between two people where one has power over the other causing fear, physical and/or psychological harm.

Note: This type of abuse can occur where people are living in the same house, between a client and a family member or friend, or between two clients.

5.2.1.2 Neglect

Neglect is a failure to provide the basic physical and emotional necessities of life. It can be wilful denial of medication, dental or medical care, therapeutic devices or other physical assistance to a person who requires it because of age, health or disability. It can also be a failure to provide adequate shelter, clothing, food, protection and supervision, or to place persons at undue risk through unsafe environments or practices and thereby exposing that person to risk of physical, mental or emotional harm. Neglect includes the failure to provide the nurturance or stimulation needed for the social, intellectual and emotional growth or well being of an adult or child.

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[10] National Disability Abuse and Neglect Hotline: *http://www.disabilityhotline.org/abuse.html#top;* NSW Interagency Guidelines for Child Protection Intervention, 2000; and Aged Rights Advocacy Service, SA: http://www.sa.agedrights.asn.au

Note: Neglect may occur when the primary carer of a client does not provide the essential elements for life described above, or when any person or organisation responsible for providing care or services to a client fails to meet this obligation.

Examples

Neglect	Refusing to provide service users with food because they have not done what they were asked to do
	Hurrying or rushing assistance with eating or drinking to fit in with staff timetables rather than clients' needs
	Withdrawal or denial of privileges, planned outings or personal items that are not designated and planned behaviour management strategies
	Depriving clients of their right to express their cultural identity, their sexuality or other desires
	Failure to ensure adequate food, health care support, clothing, medical aid or culturally relevant contexts and supports
	Not using a communication device to enable expression of needs or other communication

5.2.1.3 Physical abuse

Physical abuse is assault, non-accidental injury or physical harm to a person by any other person. It includes but is not limited to inflicting pain or any unpleasant sensation, causing harm or injuries by excessive discipline, beating or shaking, bruising, electric shock, lacerations or welts, burns, fractures or dislocation, female genital mutilation and attempted suffocation or strangulation.

Note: This type of abuse may be perpetrated by people known to clients or by strangers, and can occur at any time or place.

Examples

Physical abuse	Hitting, smacking, biting, kicking, pulling limbs, hair or ears
	Bending back fingers, bending an arm up behind the back
	Dragging, carrying or pushing people who do not want to be moved unless involuntary relocation is part of a behaviour management plan
	Physical restraint
	Threat of violence

5.2.1.4 Restraints and restricted practices

Restraining or isolating an adult for reasons other than medical necessity or in the absence of a less restrictive alternative to prevent self-harm. This may include the use of chemical or physical means or the denial of basic human rights or choices such as religious freedom, freedom of association, access to property or resources or freedom of movement. These practices are not considered to be abuse if they are applied under a restricted practice authorisation.

Note: The DADHC Behaviour Intervention policy, 2003 describes the use of restricted practices. The DADHC Restricted Practice Authorisation, December 2006 contains procedures and templates for the process. Refer to 'Position Statement and Procedures - Behaviour Intervention and Support in Applications Relating to a Person with an Intellectual Disability', Guardianship Tribunal, March 2006.

Examples

Restraints and restricted practices	The use of social isolation (ignoring a client) when it is not a designated behaviour management strategy
	Putting a client into a room with the door locked
	Locking a client in a room all night
	Using other clients to provide physical control over a client
	Expulsion for masturbating
	Excessive chemical restraint - use of medication without proper authorisation or consent
	Forcing clients to eat food they do not want to eat

5.2.1.5 Sexual assault

Any sexual contact between an adult and child 16 years of age and younger, or any sexual activity with an adult who lacks the capacity to give or withhold consent, or is threatened, coerced or forced to engage in sexual behaviour. It includes non-consensual sexual contact, language or exploitative behaviour and can take the form of rape, indecent assault, sexual harassment or sexual interference in any form.

Note: This type of abuse may be instigated by any person, against any other person of any age and of either gender.

Examples

Sexual assault	Anal or vaginal intercourse without consent
	Fingers or object inserted into vagina or anus without consent
	Cunnilingus or fellatio without consent
	Masturbation of another person without consent
	Non-consensual touching of breasts or genitals
	Indecent exposure
	Masturbation by a person in the presence of the victim
	Voyeurism
	Displaying pornographic photography or literature
	Sexual harassment, including lewd or suggestive comments, teasing or insults with sexual connotations

5.2.1.6 Emotional abuse

Includes verbal assaults, threats of maltreatment, harassment, humiliation or intimidation, or failure to interact with a person or to acknowledge that person's existence. This may also include denying cultural or religious needs and preferences.

Note: Although any person may initiate emotional abuse towards a client it is likely to come from persons who associate with clients regularly. The sources could be primary carers, family, friends, other clients or other service providers.

Examples

Psychological or emotional abuse	Humiliating a client for losing control of their bladder or bowel or about other private matters
	Treating clients in ways that deny them their dignity
	Preventing clients from expressing themselves out of fear of retaliation
	Discouraging personalisation of rooms or clothing
	Limiting social freedom available to clients
	Denying cultural needs, such as serving pork to Jewish or Muslim clients
	Shouting orders to clients
	Using humiliating names when speaking to a client

5.2.1.7 Financial abuse

The improper use of another person's assets or the use or withholding of another person's resources.

Note: Possible sources of financial abuse are carers, families or guardians who act formally or informally as financial managers and have access to or responsibility for clients' finances and property.

Examples

Financial abuse	Denying clients' access to or control over their money when they have a demonstrated capacity to manage their own finances
	Denying a client access to information about their personal finances
	Taking a client's money or other property without their consent (which is likely to also constitute a criminal offence)
	Forced changes to wills or other legal documents
	Using a client's belongings for personal use

5.2.1.8 Systemic abuse

Failure to recognise, provide or attempt to provide adequate or appropriate services, including services that are appropriate to that person's age, gender, culture, needs or preferences.

Note: Service providers and carers are the likely sources of systemic abuse.

Examples

Systemic abuse	Relevant policies and procedures are not implemented
	Clients are denied the option to make decisions affecting their lives
	Health care and lifestyle plans are not implemented

5.3 RECOGNISING SIGNS THAT MAY BE INDICATORS OF ABUSE

Staff and management play an important role in protecting clients from further harm by recognising the indicators of abuse and responding to them. The presence of one or more indicators does not mean that abuse has occurred but does require staff to be vigilant on the client's behalf.

Indicators of abuse are not always obvious, and while clients or others may suspect that abuse has occurred there might not be any evidence to confirm the suspicion. Indicators are variable, and people who are familiar with clients and have a strong positive relationship with them are best placed to recognise behavioural changes that may suggest a client is being abused.

Indicators of abuse including assault and neglect[11]

Physical Indicators	**Behavioural Signs**
Physical Abuse	
Facial, head and neck bruising or injuries. Drowsiness, vomiting, fits (associated with head injuries). Unexplained or poorly explained injury. Other bruising and marks may suggest the shape of the object that caused it. Bite marks or scratches. Unexplained burns or scalds. Unexplained fractures, dislocations, sprains.	Explanation inconsistent with the injury; explanation varies. Avoidance or fearfulness of a particular person or staff member. Sleep disturbance (eg. nightmares; bed wetting). Changes in behaviour: out of character aggression; withdrawal; excessive compliance.
Neglect	
Hunger and weight loss. Poor hygiene. Poor hair texture. Inappropriate or inadequate clothing for climatic conditions. Inappropriate or inadequate shelter or accommodation. Unattended physical problems or medical needs. Health or dietary practices that endanger health or development. Social isolation.	Requesting, begging, scavenging or stealing food. Constant fatigue, listlessness or falling asleep. Direct or indirect disclosure. Extreme longing for company. Anxiety about being alone or abandoned. Displaying inappropriate or excessive self-comforting behaviours.

[11] Adapted from:
NSW Interagency Guidelines for Child Protection Intervention 2000, revised 2005;
Elder Abuse Manual 1996 Disability Services ASAP;
Detecting and Reporting Physical, Sexual or Emotional Abuse or Neglect USA 2003; and
Australian National Disability Abuse and Neglect Hotline.

Physical Indicators	Behavioural Signs
Sexual abuse	
Direct or indirect disclosure. Sexual act described by client. Trauma to the breasts, buttocks, lower abdomen or thighs. Difficulty in walking or sitting. Injuries (e.g. tears or bruising), pain or itching to genitalia, anus or perineal region. Torn, stained or blood stained underwear or bedclothes. Sexually transmitted diseases. Unexplained accumulation of money or gifts. Pregnancy.	Repeat use of words eg “bad”, “dirty”; Self-destructive behaviour, self mutilation. Sudden changes in behaviour or temperament, eg. depression, anxiety attacks (crying, sweating, trembling), withdrawal, agitation, anger, violence, absconding, seeking comfort and security. Inappropriate advances to others. Sleep disturbances, refusing to go to bed, going to bed fully clothed. Eating disorders. Refusing to shower or constant showering. Changes in social patterns, refusing to attend usual places (work, respite). Excessive compliance.
Psychological or emotional abuse	
Speech disorders. Weight loss or gain.	Feelings of worthlessness about life and self; extreme low self-esteem self-abuse or self-destructive behaviour. Extreme attention seeking behaviour and other behavioural disorders (eg. disruptiveness, aggressiveness, bullying). Excessive compliance. Depression, withdrawal, crying.
Financial abuse	
Restricted access to or no control over personal funds or bank accounts. No records or incomplete records kept of expenditure and purchases. Missing money, valuables or property. Forced changes to wills or other legal documents.	Stealing from others. Borrowing money. Begging.

5.4 USEFUL CONTACTS

Legal advice and services

INTELLECTUAL DISABILITY RIGHTS SERVICE (IDRS)

Telephone contact: 02 9318 0144 or 1800 666 611

The IDRS provides telephone advice on a range of legal issues and representation in priority areas such as criminal law, care and protection and guardianship. IDRS also engages in policy and law reform work and undertakes community education.

CRIMINAL JUSTICE SUPPORT NETWORK (CJSN)

Telephone contact: 1300 665 908 (24 hours)

CJSN is a State-wide support and information service for people with an intellectual disability who are involved in criminal matters (whether they are victims, witnesses, suspects or defendants). CJSN, amongst other things, can provide support workers to assist a person with an intellectual disability at police interviews, at court and at related legal appointments.

LAW ACCESS NSW

Telephone contact: 1300 888 529

Law Access NSW is a website and telephone service that can assist people in finding information and other services that will assist them with their legal needs.

COMMUNITY LEGAL CENTRES (CLC)

Telephone contact: 02 9318 2355

CLC are independent organisations that provide free legal advice, information and referrals for individuals and communities in NSW, especially people on low incomes or otherwise disadvantaged in their access to justice.

DISABILITY DISCRIMINATION LEGAL CENTRE (NSW)

Telephone contact: 02 9310 7722 or 1800 800 708
TTY 02 9310 4320 or 1800 644 419

The Centre provides free legal advice, representation and assistance for problems involving discrimination against people with disabilities and their associates. However, the Centre is not a generalist legal service for people with disabilities and only assists in cases of disability discrimination under either the Australian Government Disability Discrimination Act or the NSW Anti-Discrimination Act.

Complaints

NSW OMBUDSMAN

Telephone contact: 02 9286 1000 or 1800 451 524 or TTY 02 9264 8050

The Ombudsman's Office handles complaints about a range of services and providers including public sector agencies and community services.

INDIVIDUAL AND GROUP ADVOCACY SERVICE (People with Disability Australia Incorporated)

Telephone contact: 02 9370 3100 or 1800 422 015
TTY 02 9318 2138 or 1800 422 016

This is a free, non-legal advocacy service for individuals and groups of people with a disability who have serious and urgent problems. The service is available to people with all kinds of disability across NSW. The service also gives advice and information to people with a disability and their associates about how to advocate for themselves.

Reporting abuse

AUSTRALIAN NATIONAL DISABILITY ABUSE AND NEGLECT HOTLINE

Telephone contact: 1800 880 052 or TTY 1800 301 130

The National Disability Abuse and Neglect Hotline is an Australia-wide telephone hotline for reporting abuse and neglect of people with disabilities using government funded services. Allegations are referred to the appropriate authority for investigation.

Victims' support

VICTIMS OF CRIME BUREAU

Telephone contact: 02 9374 3000 or 1800 633 063 or TTY 02 9374 3175

- The Victims of Crime Bureau is a NSW Government agency that offers support to people who are victims of crime. The Victims of Crime Bureau aims to ensure that its assistance is accessible to all victims of crime, including those with disabilities.
- Victims Support Line staff provide information on the **rights** of a victim of crime as detailed in the Charter of Victims Rights.
- The Victims Support Line staff can also provide confidential emotional support, in addition to practical information on how to access other groups and services that may assist with a victim's recovery following a crime.
- Free access to the Approved **Counselling** Scheme can be arranged through the Victims of Crime Bureau by contacting:

  Victims Support Line*:*
  (02) 9374 3000 or 1800 633 063 (Toll free)
  TTY (02) 9374 3175 (for people who use a TTY)
  Telephone Interpreting Service: 13 14 50
  Callers with a speech/communication impairment:
  13 36 77 or 1800 555 677

  http://www.lawlink.nsw.gov.au/voc
- The service includes information to victims of violent crime about applying for **compensation**[12] through the Victims Compensation Tribunal.

[12] You are eligible to claim compensation if:

- you are the victim of an act of violence and are injured as a result (primary victim); or
- you are injured as a result of witnessing an act of violence (secondary victim); or
- you are the parent or guardian of a primary victim of an act of violence who was under 18 years at the time of the act and you are injured as a result of learning of the act of violence (a secondary victim); or
- you are a member of the immediate family of a homicide victim (family victim); or
- you are injured while trying to:
  - prevent someone from committing an act of violence, or
  - arrest someone who is committing an act of violence, or
  - help or rescue someone against whom an act of violence is being committed (primary victim).

(Reference: Victims Services NSW website).

SEXUAL ASSAULT SERVICE (NSW DEPARTMENT OF HEALTH)

Staff should contact their local Sexual Assault Service for advice if they are uncertain about reporting an incident as sexual abuse.

- **24 hours at most services or telephone the local hospital after hours.**
- **Local SAS contact details are below or can be found at the following web address: http://www1.health.nsw.gov.au/services**

- The SAS provides a range of services that can include immediate care and counselling for victims of sexual assault.
- The SAS can advise staff about monitoring, documentation and duty of care issues in relation to any allegation of sexual assault.

Location	Address	Telephone numbers
Greater Southern Area Health Service		
Albury	Albury Sexual Assault Service, 596 Smollett St., Albury.	6058 1800 or 6058 4642 (AH)
Bega	Far South Coast Sexual Assault Service, Bega Community Health Centre, McKee Drive, Bega.	6492 4416
Goulburn	Goulburn Sexual Assault Service, Goulburn Community Health Centre, Cnr Goldsmith and Faithful Sts., Goulburn.	4827 3913 or 4827 3111 (AH)
Cooma	Sexual Assault Service, Cooma Community Health Centre, cnr Bombala & Victoria Sts., Cooma.	6452 1324 or 6452 1333 (AH)
Deniliquin	Deniliquin Community Health Centre 2 Macauley St., Deniliquin	5882 2900
Moruya	Eurobodalla Sexual Assault Service, Moruya Community Health Centre, River St., Moruya.	4474 1561 or 6492 4416 (AH)
Narooma	Narooma Community Heath Services Cnr Field & Graham Sts., Narooma	4476 2344
Queanbeyan	Queanbeyan Community Health Centre, Antill St., Queanbeyan.	6298 9233
Wagga	Wagga Sexual Assault Service, Wagga Community Health Centre, Docker St., Wagga Wagga.	6938 6411 or 6938 6666 (AH)
Young	Young District Sexual Assault Service, Allanan St., Young.	6382 1522 or 6382 1222 (AH)
Greater Western Area Health Service		
Bourke	Bourke Sexual Assault Service, Bourke Community Health Centre, Tarcoon St., Bourke.	6870 8899 or 6870 8888 (AH)
Broken Hill	Broken Hill Sexual Assault Service, Broken Hill Community Health Centre, Kincumber House, Morgan St., Broken Hill.	08 8080 1523 or 8080 1333 (AH)

Bathurst	Mid Western Sexual Assault Service, Bathurst Community Health Centre, William St., Bathurst.	6331 5533 or 6339 5281 (AH)
Coonabarabran	Coonabarabran Community Health Service, Cassilis St., Coonabarabran.	6842 6404 or 6885 8632 (AH)
Cowra	Cowra Hospital, Liverpool St., Cowra	6340 2356
Dubbo	Dubbo Sexual Assault Service, Dubbo Community Health Centre, 2 Palmer St., Dubbo.	6885 8999 or 6885 8632 (AH)
Lightning Ridge	Lightning Ridge Community Health Services, cnr Pandora & Opal Sts., Lightning Ridge	6829 1022 or 6885 8632 (AH)
Lithgow	Lithgow Community Health Service, Colldrewe Drive, Lithgow	6350 2750
Mudgee	Mudgee Sexual Assault Service, Mudgee Community Health Centre, Crn Church & Meares Sts., Mudgee.	6372 6455
Nyngan	Nyngan Sexual Assault Service, Nyngan Community Health Centre, Pangee St., Nyngan.	6832 1255 or 6885 8632 (AH)
Orange	Orange Sexual Assault Service, 129 Sale St., Orange	6393 3300 or 6393 3000 (AH)
Parkes	Parkes Community Health Centre, Coleman Rd., Parkes.	6862 1866 or 6861 1200 (AH)
Walgett	Walgett Sexual Assault Service, Walgett District Hospital & Health Service, 141 Fox St., Walgett.	6828 1066 or 6885 8632 (AH)
Hunter & New England Area Health Service		
Armidale	Armidale Sexual Assault Service, Armidale Community Health Centre, Rusden St., Armidale.	6776 9600 or 6776 9655 (AH)
Glen Innes	Glen Innes Sexual Assault Service, Glen Innes Community Health Centre, Macquarie St., Glen Innes.	6739 0100 or 6739 0200 (AH)
Gunnedah	Gunnedah Sexual Assault Service, Gunnedah Community Health Centre, Marquis St. Gunnedah.	6742 0666 (AH)
Inverell	Inverell Health Service, Swanbrook Rd., Inverell	6721 9600 or 6728 8300 (AH)
Lower Hunter	Lower Hunter Sexual Assault Service, 58 Stonach Ave., East Maitland.	4933 4422 or 4921 3888 (AH)
Moree	Moree Sexual Assault Service, Moree Community Health Centre, Alice St., Moree.	6757 0249 or 6757 0031 (AH)
Narrabri	Narrabri Sexual Assault Service, Narrabri Community Health Centre, 11 Cameron St., Narrabri.	6792 1522 or 6792 1666 (AH)
Newcastle	Newcastle Sexual Assault Service, Longworth Ave., Wallsend.	4924 6333 or 4921 3888 (AH)

Quirindi	Quirindi Sexual Assault Service, Quirindi Health Service, Nowland St., Quirindi.	6746 1466
Tamworth	Tamworth Sexual Assault Service, Tamworth Community Health Centre, 180 Peel St., Tamworth.	6767 8100 or 6767 7700 (AH)
Upper Hunter	Upper Hunter Sexual Assault Service, Brentwood St., Muswellbrook.	6542 2062 or 1800 642 357
North Coast Area Health Service		
Bellingen	Bellingen Community Health Centre, Church St., Bellingen.	6655 1266
Bulahdelah	Bulahdelah Community Health Service, Richmond St., Bulahdelah.	4997 4240
Coffs Harbour	Coffs Harbour Sexual Assault Service, 345 Pacific Highway, Coffs Harbour.	6656 7200
Dorrigo	Dorrigo Multi-Purpose Service, Beech St., Dorrigo.	6657 2066
Forster	Forster Community Health Centre, Breese Pde., Forster.	6555 6822
Gloucester	Gloucester Community Health Centre, Church St., Gloucester.	6558 1011
Hawks Nest	Hawks Nest/ Tea Gardens Community Health Centre, Bommer St., Hawks Nest.	4997 0186
Kempsey	Kempsey Sexual Assault Service, Polwood St., Kempsey.	6562 6066 or 6562 6155 (AH)
Laurieton	Camden Haven Community Health Centre, Laurie St., Laurieton.	6559 9003
Lismore	Richmond Sexual Assault Service, Lismore Base Hospital, cnr Laurel & Weaver Sts., Lismore.	6620 2970
Macksville	Macksville Community Health Centre, Boundary St., Macksville.	6568 2677
Port Macquarie	Port Macquarie Sexual Assault Service, Morton St., Port Macquarie.	6588 2882 or 6581 2000 (AH)
Taree	Biripi Aboriginal Corporation Medical Centre, Pacific Highway, Taree.	6552 2154
Taree	Taree Sexual Assault Service, York St., Taree.	6592 9638 or 6592 9906 (AH)
Tweed Valley	Tweed Valley Sexual Assault Service, Powell St., Tweed Heads.	5506 7540 or 5506 7510 (AH)
Woolgoolga	Woolgoolga Community Health Centre, Beach St., Woolgoolga.	6654 1111
Northern Sydney & Central Coast Area Health Service		
Gosford	Gosford/Wyong Sexual Assault Service, Biala Cottage, Holden St., Gosford.	4320 3175 or 4320 2111 (AH)
Wyong	Sexual Assault Service, Wyong Hospital, Pacific Highway, Kanwal.	4320 3175 or 4320 2111 (AH)
St Leonards	Child Health Services, RNS Hospital, Pacific Hwy., St Leonards.	9926 6060 or 9926 7111 (AH)

St Leonards	Sexual Assault Centre (16 yrs and over), Royal North Shore Hospital, Pacific Highway, St Leonards.	9926 7580 or 9926 7111 (AH)
South Eastern Sydney & Illawarra Area Health Service		
Nowra	Nowra Sexual Assault Service, Shoalhaven Hospital, Scenic Drive, Nowra.	4423 9211
Kogarah	Sexual Assault Centre, St George Hospital, Gray St., Kogarah.	9350 2494
Randwick	Child Health Services, POW Hospital, High St., Randwick.	9382 1412 or 9382 1111 (AH)
Wollongong	Wollongong Sexual Assault Service, Urunga House, 4 Urunga Pde., Wollongong	4222 5408 or 4222 5000 (AH)
Sydney South West Area Health Service		
Bankstown	Bankstown Sexual Assault Service, Bankstown Community Health Centre, 36-38 Raymond St., Bankstown.	9780 2833
Blacktown	Blacktown/ Mt Druitt Sexual Assault Service, Marcel Crescent, Blacktown.	9881 8700
Camperdown	Sexual Assault Centre (16 yrs and over) Royal Prince Alfred Hospital, L5 King George V Hospital, Missenden Road, Camperdown.	9515 9040 or 9515 6111 (AH)
Liverpool	Liverpool/Fairfield Sexual Assault Service, Liverpool Community & Allied Health, cnr Goulburn & Campbell Sts., Liverpool.	9828 4844 or 9828 3000 (AH)
Campbelltown	Macarthur Sexual Assault Service, Ingleburn Community Health Centre, cnr Moore & Cordeaux Sts., Campbelltown.	4629 2111 or 9828 3000 (AH)
Bowral	Wingecarribee Sexual Assault Service, Community Health Centre, Bendooley St., Bowral.	4861 8000 or 9828 3000 (AH)
Sydney West Area Health Service		
Penrith	Sexual assault service, Nepean Hospital, Parker St., Penrith.	4734 2000
Westmead	Sexual Assault Services (16 yrs and over), Grevillea Cottage, Westmead Hospital, Westmead.	9845 7940 or 9845 5555 (AH)
Westmead children	Level 6 Child Protection Unit/Sexual Assault Services, The Children's Hospital at Westmead, Hawkesbury Road, Westmead.	9845 2434 or 9845 0000 (AH)

5.5 POTENTIAL SOURCES OF ABUSE

The research literature suggests that abuse of women with disabilities occurs in similar situations to all women, that is, they are most likely to be assaulted by someone they know, it is most likely to be a man, and will occur in a familiar and private place. The literature also indicates that women and men with disabilities are physically abused more often than the general population[13].

Direct care staff	Have the greatest opportunity because they have extended periods of one to one contact with clients, are the providers of many of the necessities of life and assist them with intimate activities such as bathing and hygiene. They can also act as guardians and decision makers in some aspects of clients' lives. They may also have access to clients' money.
Other staff	Have regular opportunities for unsupervised contact with clients and their property. They may also have access to clients' money.
Other clients	Are in regular and close contact with clients and may have diminished responsibility related to their own disability.
Visitors	Have opportunities to spend time with individual clients and build up relationships based on trust that can later be violated.
Family members	Can spend extended periods of time with clients, away from staff and other clients, and they may have unlimited access to finances and property.
Guardians, financial managers or trustees	Are in a position to make lifestyle and health related decisions about clients and can approve the use of clients' finances.
Other service providers	May have regular contact with clients away from carers and family and are in positions of trust.
Strangers	At any time when clients are unsupervised or away from their usual environment they can be at risk of abuse from strangers.

[13] In *Violence against women with disabilities – An overview of the literature,* Keran Howe, 2000. Women With Disabilities Australia (WWDA).

Ageing,
Disability &
Home Care

Respite Care Plan

June 2010

The Respite Care Plan is a key document that gives you the opportunity to tell staff what they need to know in order to manage your family member safely and effectively.

There may be particular cultural requirements or preferences that you or your family member have for things like eating, sleeping or personal care, etc. If so, this form is the place where that information can be recorded and referred to while your family member is in respite.

The more complete and accurate the information you are able to give us, the better our staff can provide appropriate care to your family member.

If you require assistance to complete this form, please contact your Key Worker or your Case Manager.

Ageing, Disability & Home Care

Respite Care Plan

June 2010

ADHC staff to indicate any management / support plans that are attached to this Respite Care Plan by ticking box/es below. **Staff must refer to any ticked management /s support plans as they contain essential information to handle the client safely. These plans are to be used in conjunction with information contained in the Respite Care Plan.**

	Client Risk Profile (and subsequent Risk Management Plan)
	Health Care Plan
	Respite Medication Management Plan
	Epilepsy Management Plan
	Nutrition and Swallowing Checklist (and subsequent Management Plan)
	Eating and Drinking Plan
	Manual Handling / Mobility Management Plan
	Transport Management Plan
	Behaviour Support and Intervention Plan
	Communication Assessment / Plan
	Other/s (describe)

CLIENT NAME:
DATE OF PLAN:

PLAN DEVELOPMENT DATE _____ **NEXT PLAN REVIEW DUE** _____

1. THE CLIENT

Client Name		(full length photo here)	
Sex			
D.O.B.			
Address			
Home phone No.			
Mobile No.			
Height			
Weight			
Eye colour			
Hair colour			
Distinguishing features			
Disability type			
Aboriginal	☐ Yes ☐No	**Torres Strait Islander?**	☐ Yes ☐No
Country of birth			
Ancestry/cultural identity		**Religion**	
Language/s spoken			
Interpreter required?	☐ Yes ☐No	**If yes, which language?**	
Medicare Card No.		**Private Fund No.**	
Pen./Health Care Card No.			

Emergency contacts	**First Contact**	**Second Contact**
Name		
Address		
Relationship to client		
Contact phone No/s.		
Under what circumstances must you be contacted and when (eg if the client fell over and bruised his/her leg, contact immediately or on pick up)**?** Note: in case of emergencies you will be contacted immediately.		

Primary medical practitioner			
Name			
Address		**Phone**	
Fax No.		**Email**	

2. CLIENT RISK PROFILE AND SUPPORT PLANS

Does the client have a completed *Client Risk Profile*? **If no, complete this prior to first orientation stay** **If yes,** attach a copy of the ***Client Risk Profile*** and if required, attach the ***Client Risk Management Plan*** **along with any other *Management / Support Plans*** identified from the Risk Profile. Please tick relevant box /es on the front cover to indicate which plans are attached.	☐ Yes ☐ No

3. FAMILY AND SOCIAL SITUATION

	Primary carer	Secondary carer
Name		
Address		
Contact phone no/s.	**Home:**	**Home:**
	Work:	**Work:**
	Mobile:	**Mobile:**
Email		
Relationship to client (eg mother, father, aunty, etc.)		
Country of birth		
Language(s) spoken		
Interpreter required?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, which language?		
Assistance required filling out forms?	☐ Yes ☐ No	☐ Yes ☐ No
Siblings (name, age, relationship)		
Does the client currently live …	☐ With family	☐ With others
Other persons who live in the client's home		
Other persons in close contact with the client (eg. friends, relatives)		
Any other information about how the client socialises that might help with the respite stay (e.g. how they relate to new people and places, how they react when away from home, etc)		

4. CORE HEALTH INFORMATION

Is there a *Health Care Plan*? If yes please attach, if no, describe the following:	☐Yes ☐No
Diagnoses (include all diagnoses that the client may have)	
Allergies (brief description of all allergies affecting the client including reaction to those allergies) Attach any relevant allergy plans as required.	
Important medical information (brief description of medical condition/s) Attach any relevant management plans as required.	
Other health care support needs (can include things such as fluid intake, bowel care, stoma care, positioning, treatment of rashes, etc.) If a management plan is required, please attach.	
Medications	**Staff to refer to *Medication Plans* and *Charts***

5. BEHAVIOUR

Is there a *Behaviour Support and Intervention Plan* or an *Interim Plan* (if yes, attach)	☐Yes ☐No
If no, describe behaviour and management strategies that staff need to know (refer to *Guidelines* for prompt questions).	

CLIENT NAME:
DATE OF PLAN:

6. COMMUNICATION

Does the client have a communication assessment and/or intervention plan? If yes, attach a copy	☐ Yes ☐ No Date:
Does the client use speech?	☐ Yes ☐ No
If yes, is it easy or hard to understand?	☐ Easy ☐ Hard
If the client has no speech or the speech is hard to understand, what can the client use to assist the listener?	☐ Written words (reading) ☐ Pictures or symbols ☐ Photographs or Photo Book ☐ Objects ☐ A Book About Me ☐ Personal Communication Dictionary ☐ Chat Book ☐ Key Word Signing (Makaton) ☐ Use of natural gesture e.g. pointing ☐ Use of facial expression and body language ☐ Finger Spelling ☐ Other (describe)
Does the client have difficulty with vision or hearing?	☐ Yes ☐ No
Does the client require glasses?	☐ Yes ☐ No
Does the client require a hearing aid?	☐ Yes ☐ No
What supports does the client need to help them understand what is said or what is happening?	☐ None required, understands speech. ☐ Written words (reading) ☐ Pictures or symbols ☐ Photographs or Photo Book ☐ Objects ☐ Key Word Signing (Makaton) ☐ Choice Board ☐ Social Story ☐ Use of natural gesture e.g. pointing ☐ Use of facial expression and body language ☐ Other (describe)

How does the client communicate what they need? (e.g. need for toilet, wants a drink, wants something to eat)
How does the client communicate how they feel? (e.g. angry, happy, sad, pain)
How does the client communicate what they want to do? (e.g. preferred activities)
How does the client communicate "Yes" and/or "No" in answer to questions?
Does the client have preferred topics or conversation? (e.g. people, pets, toys, places, etc.)
Comment on the client's ability to use:

Telephone	
Reading	
Writing	

7. LIVING SKILLS

This information will assist respite staff to know the client's needs, likes and dislikes (refer to *Guidelines* for prompt questions).

Please note: this information does not replace the need for relevant management/support plans if the need for such plans has been identified through the *Client Risk Profile*. All relevant plans should be noted on the cover of this document, attached and referred to when providing services.

Eating and drinking:

(Attach *Eating and Drinking Plan*, *Mealtime Management Plan*, and/or *Positioning Plan* if required or describe the client's needs, preferences and/or routines.)

Dressing

(Describe the client's needs, preferences and/or routines, extent of privacy and supervision required, including any strong requirement for a male or female staff member to provide assistance or supervision.)

Bed routine

(Describe the client's needs, preferences and/or routines.)

Bathing and personal care

(Describe the client's needs, preferences and/or routines and the extent of privacy and supervision required for personal care tasks. Please indicate any strong requirement for a male or female staff member to provide assistance or supervision. Note: If the client has epilepsy, supervision must be provided while bathing and an *Epilepsy Management Plan* must be attached.)

Toileting (including menstrual care)

(Describe the client's needs, preferences and/or routines, the extent of privacy and supervision required in toileting tasks. Please indicate any strong requirement for a male or female staff member to provide assistance or supervision.)

Mobility:

(Attach *Manual Handling Plan* and/or *Mobility Management Plan* or describe what assistance the client needs.)

Other Information

Any other information respite staff require to ensure that the client has a positive experience in respite? (e.g., daily routines, likes/dislikes with regards to things like listening to music, watching movies, playing games, being indoors or outdoors, having a favourite toy, etc.)

8. RECREATION AND OUTINGS

Would the client like to participate in recreational activities and outings whilst in respite if possible?	☐Yes ☐No
Does the client have *a Mobility or Transport Management Plan*? If yes, attach	☐Yes ☐No
If no, describe what assistance client requires with mobility or transport (refer to *Guidelines* for prompt questions)	

What type of recreational activities does the client enjoy or dislike?
Are there any activities that the client cannot participate in due to medical reasons? (e.g., trampoline, gymnastics) **or cultural/religious reasons?**
Are there any factors that affect or upset the client, such as noises, animals, crowds or fireworks?
Is the client able to look after their own pocket money on outings and if so, how much money can they manage?
Is the client able to look after their own possessions on outings (e.g. back pack, clothing, mobile phone, ipod)**. If not, what kind of assistance do they require?**

Can the client participate in outings that involve water sports / swimming?	☐Yes ☐No

Does the client require assistance in or around water and if so what assistance is required? (If the client has epilepsy, supervision must be provided in and around water and an *Epilepsy Management Plan* must be attached.)

CLIENT NAME:
DATE OF PLAN:

Supervision during outings

Does the client have a *behaviour plan/reactive strategy*? If yes, attach	☐Yes ☐No
If no, describe level of supervision required on outings (refer to *Guidelines* for prompt questions)	

Other Information

Any other information that staff may need relating to recreation and outings?

9. SCHOOL, WORK OR DAY PROGRAMS

Does the client attend school, work or day programs?	☐Yes	☐No
Name of school, work or day program		
Address		
Contact person		
Phone no.		
Email address		
What are the days and hours of attendance?		
Is there any other information regarding school, work or day placement that staff need to be informed of while client is in respite? (e.g., sports days, lunch provided on certain days, etc)		

Is transport provided to the school, work or day placement?	☐Yes ☐No
If yes, with whom? (include contact details)	
At what time is the client picked up from the respite centre?	
At what time is the client dropped off at the respite centre?	
If transport is not provided, how does the client get themselves to school, work or day placement?	

Who was involved in preparing this Respite Care Plan?

Signed (carer/family member):

Print name

Signed (Manager):

Print name

Date:

10. AGREEMENTS

Emergency medical treatment

I, (parent / carer / guardian) understand that substitute consent is not required for medical treatment if, in the opinion of the practitioner, treatment is necessary as a matter of urgency to:

- *save a persons life*
- *prevent serious damage to a person's health*
- *alleviate significant pain or distress*

I understand I will be contacted as soon as possible by the respite service staff. I agree to pay the cost of any medical attention received.

SIGNED: **DATE:**

Participation in recreation and outings

I, (parent / carer / guardian) give permission for

(client's name) to participate in community access / recreation outings / transport outings. I understand that I can withdraw my permission at any time.

SIGNED: **DATE:**

Letter opening / reading of communication book

I, (parent / carer / guardian) give permission for the staff of the respite service to open and read any letters and/or communication books sent in my son / daughter's bag from his/her day placement / school whilst he/she is staying at the respite service. I understand that I can withdraw my permission at any time.

I place the following restrictions on my permission:

SIGNED: **DATE:**

Photography

I, (parent / carer / guardian) hereby give permission for the staff of the respite service to film / photograph my son / daughter whilst he/she is staying at the respite service.

I understand these photographs will be used for identification purposes and to assist the client in programs identified in their respite care plan.

I place the following restrictions on my permission:

I understand that this permission is only valid for a period of 12 months and I can withdraw my permission at any time.

SIGNED: **DATE:**

Authority to make decisions in absence of carer/family

Will you be contactable while your family member is in respite? ☐Yes ☐No

If no, please complete the following:

I will not be contactable between and

I nominate as the person authorised to make decisions on my behalf during this time.

The contact details of my nominee are:

I give my nominee permission to make decisions about the following matters:

I place the following restrictions on my permission:

I acknowledge that my nominee has agreed to be the person responsible for making these decisions.

SIGNED: **DATE:**