DD's Compassionate Support Pty Ltd.

NDIS

Support Planning Procedure

Policy area	Support Planning
Document type	Procedure
Applicable to	DD's Compassionate Support Pty Ltd
Version	V05.001
Date approved	01 June 2024
Approved by	Director
Next review date	30 June 2026
Policy Sponsor	Director
Related policies	Support Planning Policy Service Delivery Policy Service Access and Exit Policy Safeguarding Against Violence, Abuse, Neglect, Exploitation and Discrimination Policy Client Health and Wellbeing Policy Risk Management Policy Emergency and Disaster Management Policy Covid-19 Response Policy Duty of Care Policy Diversity Policy Transition of Care Between Different Environments Policy Client Living Alone and Receiving Personal Care from a Sole Worker Policy Human Resources Management Policy Work Health and Safety Policy Consent Policy Client Advocacy Policy Conflict of Interest Policy Manual Handling Policy Continuous Improvement and Quality Management Policy Client Feedback and Complaints Management Policy Medication Management Policy Mealtime Management Policy Privacy Policy
Authority	NDIS Act 2013 NDIS Practice Standards and Quality Indicators NDIS Code of Conduct UN Convention on the Rights of Persons with Disabilities UN Convention on the Rights of the Child Aged Care Act 1997 Aged Care Quality and Safety Standards Aged Care Code of Conduct

PURPOSE

The purpose of this procedure is to explain how our organisation plans client services and supports.

SCOPE

This procedure applies to all our workers (employees, contractors and volunteers).

DEFINITIONS

Term	Definition
Dignity of Risk	A person's right to make an informed choice - even if the choice involves some risk.

CONTEXT

Our organisation will collaborate with the client, their family/alternate decision-maker/advocate and other stakeholders to plan client services and supports that achieve the best outcomes for the client. We will do this in a way that:

- encourages and supports them to adopt and maintain good nutrition and healthy lifestyle habits;
- best suits their individual needs, abilities, circumstances, preferences and goals;
- safeguards them against violence, abuse, neglect, exploitation and discrimination;
- escalates health-related issues, concerns and risks promptly and appropriately;
- provides choice, control and self-determination;
- is culturally safe;
- upholds their privacy and dignity;
- promotes community participation and engagement;
- enables independence and capacity-building where possible; and
- empowers them to live their best life.

PROCEDURES

1. Collaborative Approach to Support Planning

1.1 Partner with the client, and/or the family/alternate decision-maker/advocate as appropriate, to establish the agreed method for designing the Support Plan to ensure the client's requirements and preferences are incorporated.

1.2 Seek input from the client to understand their capabilities and functional skills and assist them to design supports which build on these and create independence and resilience to achieve goals.

1.3 Discuss with the client other services and supports they may need or want and when and how they would like other people in their support network (family, friends, carers) to be involved in their care.

1.4 Discuss with the client their physical, emotional, spiritual, cultural, community, social and financial needs and preferences and what strategies, services and supports will best meet these needs.

1.5 Discuss with the client ways they can/would like to develop and maintain social connections and relationships (including intimate relationships).

1.6 Seek and provide information for the client to consider in line with their preferences and goals.

1.7 Discuss with the client ways to include safeguards in their Support Plan and strategies to respond to emergencies, disasters and foreseeable life events.

1.8 If relevant and appropriate, establish whether the client and/or their family/alternate decision-maker/advocate would like to include advance care, palliative care and/or end of life planning in the assessment and planning process. If so, collaborate with stakeholders to identify and develop strategies in accordance with the client's needs, preferences and goals.

1.9 Discuss with the client about information-sharing to optimise support planning and obtain their written consent to share information with other providers.

1.10 Contact other service providers working with the client to share information, with the client's consent, and discuss options to maximise the client's health and wellbeing.

1.11 Collaborate with relevant stakeholders to ensure clients with complex care needs are provided with access to a full range of required supports (allied health, health and social support services). If required, organise a meeting with all stakeholders.

2. Risk Management

2.1 Identify and discuss with the client any environmental risks in the client's home and strategies to mitigate these risks.

2.2 Ensure any equipment we provide that is used in the delivery of care or services is safe and meets the assessed needs of the client.

2.3 Ensure the Individual Risk Profile, Safe Environment Checklist, Personal Emergency Preparation Plan and Support Plan are completed, reviewed annually and recorded in the client's file.

2.4 Complete a risk assessment and a Continuity of Care Backup Support Form for a client transitioning services in accordance with the Transition of Care Between Different Environments Policy and Procedure.

2.5 Organise for an annual comprehensive risk assessment to be completed with input from the client's doctor.

3. Service Agreement and Support Plan

3.1 Develop a Service Agreement that establishes the responsibilities and expectations of both parties and the terms and conditions associated with the delivery of services.

3.2 Ensure the client has adequate time to read the Service Agreement and consider their options. Ask the client if they have any questions or concerns (including in relation to fees and charges) or if they would like anything clarified. Discuss with them their right to seek external advice and their right to an advocate to speak on their behalf before they sign the Agreement.

3.3 Ensure information in the Service Agreement and Support Plan (including emergency contact details) are clearly documented, accurate and up to date and accessible to all relevant stakeholders.

3.4 Review (and organise required revisions to) the Support Plan annually as a minimum, and also if there is a:

- change in the client's needs, preferences or goals;
- change in the availability, capacity or responsibilities of others involved in the client's care (e.g. family or friend);
- new risk is identified; or
- there is a change or incident that impacts the client.

SUPPORTING DOCUMENTS

Related procedures and forms include:

- Support Plan
- Support Plan — Easy Read
- Service Agreement
- Personal Emergency Preparation Plan
- Emergency and Disaster Management Procedure
- Participant Information Consent Form
- Participant Safe Environment Risk Assessment
- Continuity of Care Backup Support Form
- Service Access and Exit Procedure
- Service Delivery Procedure
- Safeguarding Against Violence, Abuse, Neglect, Exploitation and Discrimination Procedure
- Risk Management Procedure

- Emergency and Disaster Management Procedure
- Covid-19 Response Procedure
- Client Advocacy Procedure
- Diversity Procedure
- Client Living Alone and Receiving Personal Care from a Sole Worker Procedure
- Transition of Care Between Different Environments Procedure
- Infection Management Procedure
- Manual Handling Procedure

RESPONSIBILITIES

The Director is responsible for:

- maintaining this procedure and associated documents;
- ensuring the procedure is effectively implemented across the service;
- monitoring workers compliance with the requirements of this procedure; and
- ensuring training and information is provided to workers to carry out this procedure.

All workers are responsible for complying with the requirements of this procedure.

COMPLIANCE

Deliberate breaches of this procedure will be dealt with under our misconduct provisions, as stated in the Code of Conduct.