Expected Outcome

The Service has a culture that is inclusive and welcoming that celebrates community diversity in all its forms (including cultural diversity, religious diversity, financial status, sexual preference, disability, gender identity). This document has been formed in consultation with Kurrajong Waratah Disability Services and clients 776, 1065 & 1066

Training Requirements

All Team Members

Procedure

Individualised assessment and care planning will include Service User diversity and preference when designing the Service Care Plan.

Practices designed to cater to individual Service User diversity & need include:

- Choice of day of service
- Choice of time of service
- Choice of type of service (e.g. individual transport, group transport, travel training, taxi vouchers etc)
- Choice of type of assistance (e.g. may require increased allocation of time to allow Service User to independently get to vehicle, may require two Team Members to assist Service User)
- Choice of type of Team Members (e.g. Service User may require a woman driver)
- Type of Vehicle allocated (e.g. car, bus, wheelchair access etc)
- Choice of Booking method (e.g. phone, advocate, other service provider)
- Use of interpreters

Service Users from Culturally & Linguistically Diverse Backgrounds

In cases where the Service User does not speak English an interpreter service will be used to ensure that the Service User understands the assessment and review process, the services being offered and the general information provided in the Service User Information Handbook. If the Service User is in the process of accessing other services a joint assessment will be canvassed with the Service User.

The need for an interpreter service will be clearly identified at assessment. As much as possible an interpreter will be used in place of a family member or friend of the Service User. Having an independent interpreter may make the Service User feel more comfortable to discuss sensitive issues and will result in a more thorough assessment of the Service User's needs.

Contact with and working relationships will be made and maintained with other groups that offer services to culturally and linguistically diverse groups as detailed in

the CIARR Protocols and in Relevant Networks & Forums document and in the Promotional Material Distribution Points document.

Steps	Action/Evidence	Who does it	When
1	Book Interpreter	Assessor	ASAP after referral received
2	Conduct Assessment & Provide information	Assessor & Interpreter	At assessment
3.	Develop service plan to ensure inclusion	Assessor ensures Team Members aware of Service User need	Prior to service commencing
4	Invite organisations with cultural diversity to participate in service activities and/or the Service visits those orgs to allow interaction of Service Users	Manager	At least every 6 months
5	Reviews include consideration of Service Users changing needs	Assessor	At least every 6 months
6	Appropriate referrals are made	Assessor	As soon as need identified

Service Users Who Cannot Read or Write

In cases where a Service User cannot read or write, Team Members will ensure that the information regarding the assessment, review, care plan and services are clearly explained and understood by the Service User.

Steps	Action/Evidence	Who does it	When
1	Service User identified as not being able to read or write	Service User/Assessor	As soon as becomes evident
2.	Assessment process and information clearly verbally explained to Service User	Assessor	At Assessment
3	Service Care Plan records Service Users needs	Assessor ensures Team Members aware of Service User need	Prior to service commencing

4	Reviews include consideration of Service Users changing needs	Assessor	At least every 6 months
5	Appropriate referrals are made	Assessor	As soon as need identified

Service Users with Dementia/Brian Injury

To whatever extent possible the Service User with dementia will be given the same information as other Service Users and their questions answered. For people with severe dementia or severe intellectual, psychiatric or brain injury disabilities, the focus will be on ensuring that the carers and/or advocates are fully aware of the contents of the Service User Information Handbook and the information regarding assessment, review, care plans and services.

Team Members will receive training in how to work with people with dementia or specific brain function disabilities and every effort will be made to ensure that services are delivered in an appropriate and sensitive way.

Service Users with Dementia or other brain function disabilities will be referred to appropriate agencies should the Service be unable to continue to provide the level of support needed by the Service User.

Steps	Action/Evidence	Who does it	When
1	Service User identified as having dementia or other brain function disability	Service User/Carer/ Assessor	As soon as becomes evident
2.	Assessment process and information clearly verbally explained to Service User and carer/advocate	Assessor	At Assessment
3	Written information provided to Service User/carer/advocate	Assessor	At assessment
4	Service Plan records Service Users needs	Assessor ensures Team Members aware of Service User need	Prior to service commencing
5	Reviews include consideration of Service Users changing needs	Assessor	At least every 6 months
6	Appropriate referrals are made	Assessor	As soon as need identified

Service Users with Challenging Behaviours

The Service insists that Service Users with challenging behaviours should be supported, and their family and advocate advised about the best ways to assist. In providing a “positive approach” in service delivery, the balance between duty of care, dignity of risk and work health and safety issues must be carefully balanced.

A positive approach will also involve referral to services that can assist with developing specific "behaviour intervention" strategies with the Service User to be included in Service Plans in the event of an emergency involving a Service User using prohibited practices. These plans will give more support to the Service User with challenging behaviours and a set procedure will be followed:

- the incident must be reported to the Manager;
- the Service User should be, if possible, gently removed to a quiet, safe area to protect themselves and others;
- a referral will be made to ensure a full assessment is carried out by qualified personnel to ensure future skill development and support of the Service User with challenging behaviour;
- The Service User will not return to the Service until appropriate plans have been developed to assist in addressing the challenging behaviour. The Guardianship Board may need to be notified; or
- An alternative service, more in keeping with the Service User's needs may need to be found.

Problems making informed decisions can also lead to challenging behaviours Team Members will consult the Ascertaining Service User Capacity to Make Informed Decisions Procedure.

Steps	Action/Evidence	Who does it	When
1	Service User identified as having challenging behaviours	Service User/Carer/ Assessor	As soon as becomes evident
2.	Assessment process takes into account behaviours exhibited and positive approaches that may lessen the behaviour. In-depth discussions will be undertaken with family/carers/advocates regarding these interventions	Assessor	At Assessment & review
3	Written information provided to Service User/carer/advocate	Assessor	At assessment
4	Service Plan records Service Users needs and appropriate interventions	Assessor ensures Team Members aware of Service User need	Prior to service commencing

5	Reviews include consideration of Service Users changing needs and success or failure of interventions. New interventions developed as needed	Assessor/Service User & Carer	At least every 6 months
6	Appropriate referrals are made	Assessor	As soon as need identified

Service Users with Psychiatric Disability

Not all people with a mental illness have a psychiatric disability. Only people with psychiatric disabilities are eligible for HACC Services. Team Members will receive training in working with people who have a psychiatric disability and every effort will be made to ensure that services are delivered in an appropriate and sensitive way.

Mental Illness according to the NSW Mental Health Act 1990 is:

"a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterized by the presence in the person of any one or more of the following symptoms:

a. Delusions
b. Hallucinations
c. Serious disorder thought form
d. A severe disturbance of mood
e. Sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in point's a-d."

A Psychiatric Disability according to the NSW Disability Services Act (1993) a person has a psychiatric disability if:

"their mental illness will most likely be permanent (even if episodic) and results in a significantly reduced capacity in one or more areas of major life activity."

People in the acute stages of an illness are NOT HACC Target group and it may be necessary for the person to temporarily leave the Service. Once the acute episode is treated and the Service User is again stable, return to the Service will be encouraged.

Dual Disorder/ Dual Disabilities refer to the existence of any two co-occurring disorders or disabilities.

The Service will support Service Users with a psychiatric disability and their family. If the Service User is also a Service User of Area Health's Mental Health Team the Mental Health/HACC Protocols will be applied. In providing the positive approach in service delivery, the Services obligations regarding duty of care, dignity of risk and occupational health and safety issues will be carefully balanced.

After an assessment of a Service User, a specific care plan will be created to suit the individual Service User and their specific area of need. This will ensure that the

Service User has equal access to the services and that they are treated fairly and with respect. Continual monitoring will occur of the Service User and their care to make certain that the program is benefiting the Service User in all aspects of their lives.

The Manager will ensure that the Team Members are properly trained in assisting with Service Users with a psychiatric disability.

Step	Action/Evidence	Who does it	When
1	Service User identified as having a psychiatric disability	Service User/Carer/ Assessor	As soon as becomes evident
2.	Assessment process takes into account psychiatric disabilities experienced due to the Service Users mental illness. Signals and/or warning signs of the Service User becoming acutely ill are discussed to enable quick referral and positive approaches to address the Service Users illness. In-depth discussions will be undertaken with family/carers/advocates regarding these interventions	Assessor and appropriate Mental Health service and/or persons GP (with the Service Users permission)	At Assessment & review
3	Written information provided to Service User/carer/advocate	Assessor	At assessment
4	Service Plan records Service Users needs and appropriate supports	Assessor ensures Team Members aware of Service User need	Prior to service commencing
5	Reviews include consideration of Service Users changing needs and success or failure of supports provided. New supports developed as needed	Assessor/Service User & Carer & appropriate Mental Health Service and/or GP (with the Service Users permission)	At least every 6 months
6	Appropriate referrals are made	Assessor	As soon as need identified

Documents to be completed and/or related to this procedure

- CIARR Protocols
- DOC 3.02-1-1 Service User Information Handbook
- DOC 3.04-1-1 Service User Codes

- DOC 3.05-2-3 Service Plan Flowchart

Corresponding Policy

- POL 3.04 Diversity

Relevant Standard

Community Care Common Standards

2.1 Service Access

2.2 Assessment

2.3 Care Plan Development & Delivery

2.5 Service User Referral

3.5 Independence

Disability Service Standards

1. Rights
2. Participation and integration
3. Individual outcomes
4. Feedback and complaints
5. Service access
6. Service management

Procedure History

No: 3.04-1	Diversity		Date Approved		
Date Procedure due to be reviewed	Date Procedure Reviewed:	Amendments	Positions informed/trained regarding amendments	Method	signature
18/3815	5/3/15			Board	