# POSITIVE SUPPORT PROPOSALS
# by the
# EASTERN REGION of DHS VICTORIA

**Most of the following proposals have for years been totally foreign to most DHS management and staff. Indeed, most direct care staff would consider the following as a load of rubbish. A Community Visitor Report, obtained under FOI states,** "Community visitors concerned with staff not following instructions regarding active support, because of staff conflict, with staff sticking by a "basic care" attitude. There was a letter produced by an unknown person stating that 'active support' was not in the basic care that DDSO workers provide"

## FAMILY CONNECTIONS

### Ideas from the Inner East House Supervisors
### 9 August 2011

### Ideas to Improve Communication with Families

- Use the positive connections questions from VALID to get baseline
    - Electronic version to be emailed out.
- Newsletter – 1 monthly to 3 monthly.
- Send a card – and recent pictures.
- Regular phone call / emails – diarise
    - Updates of what is new, where we've been lately, health.
- Afternoon teas.
- Invite families out for meals.
- Go and visit – especially if older and/or far away.
- Christmas BBQ, grand final day, Easter, etc
    - Invitations bring a plate.
- Little gifts people have made / chosen themselves
    - Father's day / mother's day / birthdays
    - For brothers, sisters, nephews, nieces.
- Challenge history.
- Regular agenda on house meeting
    - "in your shoes" exercise
    - Keyworker role
    - Our house quality plan, teach expectorations.

- Invite to birthday parties & Christmas parties.
- Monthly news letter.
- Three monthly family meetings.
- Encourage people we support to ring their families.
- Weekly phone calls to siblings.
- Encourage family to attend important medical appointments.
- Assist person to visit family in the country.
- Invite families to PCP meetings.
- Update by phone call re problems, issues and good stuff too.
- Send photos via mobile phone to sister in Sydney with a message.
- Set a day and time to call each week to prevent 'overkill'

### Connecting Families and Friends in Group Homes

- Encouraging family member to use the 'carers pass' (Companion Card)

    - Attend movies
    - Attend productions / concerts
    - Train rides outings.
- Families who live interstate / long way away
    - Arrange day trips / picnics with family and friends.
- Families over for dinner / afternoon tea
- Creating culture where families come regularly into the group home for a "meeting – afternoon tea, hang out".
- Monthly newsletter prepared by residents for families.
- Involving families when moving / change in house setting up 'homely' environment.

- Phone numbers – easy read for people.
- Cards – mothers day, fathers day, Christmas and birthdays.
- Invitations to special events / meetings.
- Newsletter – at the house – every three months.
- Technological communications – e.g. SKYPE or emails.
- Regular contact by phone re updates
    - Health / recreation.
- Support with visits to families, at the house or nursing home.
- Letters.
- Drawings and photos.
- Local links to friends that live in the local area.
- Connections with people at hobbies / community venues
    - Messed
    - Hockey games
    - Local shops
    - Art classes
    - Church
    - Local band
    - Discos.
- Friends through holidays – making new friends.
- Maintaining the connection through day placements.
- Putting into practice.
- PCP goals
- Quality plan
- Communicating to others (staff, family day program).

- Phone calls
    - Birthdays
    - Individual
    - Current health concerns.
- Home visits
    - Updated program information
    - Informing parents – maybe talking between parents / Drs
- Via emails to parents to give information.
- New equipment at residence family have to access connections.
- Photos / cards new keyworker to inform parents of the change of key worker.
- SKYPE
    - Open communications between families, via emails weekly about what happened through the week in the group home.
    - Individual talks to families weekly relating to the group home.
    - Partnership between homes / staff.
        - Key worker to send monthly photos / cards.
- Three monthly newsletter, family meetings,
- Companion Card

- Nation Disability Insurance Scheme (NDIS).

**FAMILY CONNECTIONS**

**House Supervisors Meeting held on the 10 August 2011**
**Central & Outer Areas**

## What's Working Well

- Newsletters from group homes to families and friends
- Resident meetings
    - Themes for people / home / staff
- Supporting home visits for people and their families
- Honest open approach
    - Walking alongside families
    - Involving extended family members and friends. Eg. Brothers, sisters, nephews, nieces etc.
- Invite family to appointments
- Keyworkers system going well
- Involve family re-choice of medical professionals
- Transport residents to aging residences
- Meetings/party 3 monthly with significant others.
- Sharing good news/achievements
- E-mail once a month with family members.
- Phone calls (on loud speaker for people who don't use speech to communicate)
- Emails
- Afternoon teas
- Working bee and BBQs
- Families over for dinner
- Resident meetings involving families
- Parties – Christmas, birthdays etc
- Invite to special outings
- Provide individualised communication to families (newsletter)
- Family involvement in PCP etc.
- Family brunches
- Most importantly meeting individuals needs
- Work with them.

## What Can We Do Better

- Communication
    - Minutes / information / resident meeting to families
- Getting Toni's message across to all staff
- Smaller more intimate family get-together's, rather than big functions.
- Provide "confidential" and "private" space.
- Display empathy – walking in their shoes
- What do they want to know about medical issues
- Involving family members who are not actively involved – 3 monthly
- Inform about small issues.

## Good Ideas

- How do we connect with our residents 'important people"
- News
- Emails/photos re outings
- Easter }
- Christmas } celebrate – invites to house/out to dinner
- Birthdays }
- Key worker – letters/report with photos
- Slide show on a DVD to music
- Take digital camera everywhere
- Phone calls
- Facilitated; outings, visits.
- Oban road → took parents on a holiday
- Major purchases $ inform/talk
- Health : invites and updates
- Conversation about what they want
- Guilt free (imposed – be careful).

**What we took Out of today and what we can do…**

- Valid – great proforma
- Let families know when you are on leave
- Empathy – staff to have a deep understanding
- Invite parents in an informal way to tell their stories
- Change management/communication
- Initial CRU visit
- Consistent team.
- Open and honest communication
- Emails are a fantastic tool
- Parents need to be a legitimate part of the process
- Desperation of families
- Everyone unique – not a stereo type
- Services – where are they
- Sister started pen pal with niece (interstate)
- Allowing compliance i.e. accepting you do???
- Technology – Face book
- Beyond mum and dad
- Staff forums i.e. Lunch time
- Casual orientation
- Certificate V – subject.
- An understanding of life's journey
- Families anxieties
- Empathy for child's mile stones
- Importance of family involvement
- Families are aware of staff issues/conflicts.
- We work with human beings fine links objectivity/subjective
- More empathy
- Far too??? with constant staff/structure change
- Its not a generic response – every situation is different
- Staff play an important role in how family feel about the care their child is receiving
- Visible look of a child looking neat and care for
- Mutual respect
- Constructive criticism.
- Understanding families' pain.
- The system has dehumanised families
- Staff and families are often on different wave links about what residents want
- How do we educate families about current trends, when staff are struggling
- Need to make proactive contact

- Reactive contact only
- Sending photos, letters
- Father takes his daughter to an evening program.
- Fear
- Parent's love different
- Grief/loss ongoing
- Milestones in life different.

**Challenge for Action/Change**

- Daily reality
- Conflict of support
- Mixed values
- Guilt
- Understanding.
- Don't judge families
- Listen and learn
- Recognise the contribution families have in the lives of their children/siblings
- Family as equal partners
- Recognition of future needs. E.g. new families entering group home
- Different expectations e.g. Treated as they were at home
- Appropriate transition for new house members.
- Appropriate placement of new residents, more input from families of existing residents
- Everybody, families' residents, staff all understand the goals and aspirations for that person.

# Positive Connections

DAS (Disability Accommodation Services) is committed to maintaining and building meaningful connections for residents living in their accommodation. This is not only aimed at supporting residents to have a good quality of life, but also acknowledges residents' right to family contact, friends, community and relationships.

## AIMS

1. To support residents to maintain connections and relationships with significant others, such as friends and family.

2. To promote family and friends involvement in the life of residents.

3. To support residents to develop positive connections with others in their support network (eg. work/day setting) and community.

**POSITIVE CONNECTIONS MAPPING**

## Acknowledging Family Connections

*Name & relationship of each of family members:*

_____ _____

_____ _____

_____ _____

_____ _____

*Ask each family member how they want to be:*

1. Regularly communicated with? eg. phone, visits, mail

_____

_____

2. Involved in the house? eg. events, birthday party's, family meetings

_____

_____

3. Involved in family members care? eg. taking to GP &/or specialists, copies of info

_____

_____

4. Involved in planning support & care? eg. Support Plan, Behaviour Plan

_____

_____

5. Kept up to date with changes or problems? eg. phone in evening, letter, meeting

_____

_____

6. Involved in their family members life in other ways?

_____

_____

# House Information

Name of Key Worker & brief info on their role (or provide info sheet on the role):

_____

_____

Name of House Supervisor

_____

Usual time when the resident's Support Plan is reviewed:

_____

Day Program or work name & amount of time resident attends:

_____

_____

Key Worker (or if none Coordinator) at Day Program/Work

_____

Guardian &/or Administrator

_____

## Acknowledging Friends & Other Connections

*Ask each friend/significant other how they want to be involved:*

*Name & relationship of each of friends/others:*

_____ _____

_____ _____

_____ _____

_____ _____

*How do the they want to be:* (NOTE: may need to duplicate this section for each person)

1. Regularly communicated with? eg. phone, visits, mail

_____

_____

2. Involved in the house? eg. events, birthday party's, family meetings

_____

_____

3. Involved in resident's support? eg. outings,

_____

_____

4. Involved in planning support & care? eg. Support Plan, Behaviour Plan

_____

_____

5. Kept up to date with changes or problems? eg. phone contact, letter, meeting

_____

_____

6. Involved in the resident's life in other ways?

_____

_____

**IDEAS OR GAPS**

After doing this information gathering on connections for a resident, you may notice clear gaps or have ideas on people they already know that could become a stronger connection for the resident. Write these here:

_____

_____



_____

_____

# Connections Map


Christine lives at 24 **Hope Street**, Timbucktoo

The House Supervisor as of 9th August 2011 is Sally Lutter & her Key Worker at Hope St is Silvia Warren.

## Christine's family connections are:

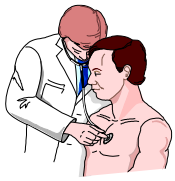
Carol & Roy her mum & dad who live nearby

Her sisters live interstate but keep in contact regularly

Carol & Roy would like:

* To have an **update by phone** each weekend to see how Chris has been during the week
* To be notified in person when they visit or by phone if there are any **problems or issues** impacting on their daughter
* The family like copies of all relevant paperwork, eg. CERS

* They love attend any **events** at the house & are happy to support staff with any events involving Chris



* Although Carol would like to attend all dental or **Doctors** appointments, she is unable to do so due to health. However, she does want to be informed when:
  - Chris is unwell or needs to go to see a specialist
    - to have a copy of any assessments & Chris's Health Management Plan sent to them
    - of times of specialist appointments as she will try to accompany staff to these


* To be given the choice of where & when Chris's **Support Plan** & Behaviour Management plan reviews are held so that they can be involved
* They also would like an **electronic copy** of the Plan if possible so they can send it to Chris's sisters to keep them in the loop.

* Carol & Roy **visit** Christine during the week after she returns from work, ie. around 4pm.

* Chris spends a few days in **each holiday** period at home & also stays over when her sisters visit

- Chris's **sisters** like to receive birthday cards from her

## Christine's Other Connections

### Friends

* Christine has two **best friends** from her work at Ok Enterprises – Sam & Robyn
* Chris likes to go to the movies with Sam & Robyn
* They also see each other at the Thursday **disco** when they go
* Robyn likes to ring Christine to have a chat


* Christine has also started craft on Saturdays at the Community House. She has made a

### Neighbourhood / Community

* Chris likes to chat with Ted the shopkeeper at the local corner store when we go to buy milk or the newspaper
* All the ladies in the house have invited the neighbours around Hope Street to a couple of BBQ's
* Chris would like to have more friends in the community

### Other

* When required Chris & her family have been supported by an **advocate** from Eastern Advocacy
* She catches up for coffee with her advocate every couple of months.

Reviewed during Support Plan review July 2011
By Silvia

# Eastern Metropolitan Region
# Disability Accommodation Services
# Keyworker
# Roles and Responsibilities

**EMR would like to acknowledge the development of the original keyworker framework by North West Metropolitan Region**

## The Keyworker duties are underpinned by the following

### The Department of Human Services Values:

- ✓ Client Focus Professional Integrity
- ✓ Collaborative Relationships
- ✓ Quality
- ✓ Responsibility.

### The Disability Act 2006


- ✓ The provision of quality services
- ✓ Planning
- ✓ Monitoring and Reporting
- ✓ Active Support
- ✓ Community participation and Inclusion.

### The Victorian Charter of Human Rights; Human rights are:

- ✓ the basic rights that belong to all people simply because we are human beings
- ✓ about recognising and respecting the dignity of other people
- ✓ the foundation for freedom, justice, peace and respect
- ✓ an essential part of any democratic and inclusive society that respects the rule of law, human dignity and equality.

## The Quality Framework for Disability Services

The **Outcomes Standards** for Disability Services in Victoria describe what is important for people with a disability as citizens of Victoria. These standards prompt us to consider the influence and impact that we have upon the political, social, cultural, economic and physical wellbeing of people with a disability.

These can be identified through the **16 Life Areas:**
Being Safe, Looking After Self, Being Independent, Moving Around, Choosing Supports, Paying for Things, How to Live, Where to Live, Doing Valued Work, Always Learning, Communicating, Building Relationships, Being Part of a Community, Having Fun, Expressing Culture, Exercising Rights and Accepting Responsibilities.

The **Industry Standards** for Disability Services in Victoria describe the systems and processes we need to put in place to ensure better services for people with a disability.

## Disability Development and Support Officer: Job description

Assisting people with a disability with their daily activities, by facilitating the development and enhancement of independent living and other skills. Disability workers develop and implement programs aimed at achieving an individual's goals and aspirations and enhancing the individual's participation in the community.

Complete administrative work maintaining client records and household accounts.

Polices and procedures as outlined in the Residential services practice manual.
Advocating for people with a disability and provide other assistance where required.

### Keyworker Definition

A staff member allocated to an individual for the purpose of coordinating immediate and long term support needs, ensuring that planning outcomes are met and the person's wellbeing is maintained.

***The keyworker is someone who has responsibility for ensuring that a named service user receives a high quality, personalised service accordining to his / her needs and wishes.***

***The keyworker is not solely responsible for delivering the service; this is the role of every member of the support staff when on duty. The keyworker, however, builds a closer relationship with the service user and their supports, in order to become more acutely aware of their needs and wishes. (Pearce and Smith, 2000, unpaginated)***

### Keyworker Allocations

Staff are assigned a keyworker role based upon on one or more of the following:

- Current working relationship with the identified person, family or advocate
- Skills and knowledge required to meet the persons support
- Gender / Other preferences or request made by the person
- Rostered hours measured against tasks / actions required for the identified person

House Supervisors are responsible for assigning keyworkers by assessing staff competencies and matching to individual resident using the criteria above.

Keyworkers are generally allocated during the individuals annual planning cycle (12 months) and it is good practice for all staff to rotate through these allocations to gain a broader awareness and understanding of all people within that group home.

Where keyworkers are to be rotated, this again should also be done during the annual planning cycle. The new keyworker will be provided with an opportunity to receive a handover and be introduced to the resident's family and support networks.

**The annual planner is used as the planning schedule, outlining the yearly requirements required for each person, and the required business systems within the group home. The monthly keyworker report is a written summary of what has occurred for the person and the outcomes for that month.**

**Reporting Requirements**

Keyworkers are directly supervised by the House Supervisor and or DDS0 2 and must not implement actions without prior consultation and / or direction. Keyworkers are to review their tasks and actions each month and submit the keyworker report at each house meeting and be discussed at monthly professional development and support, (PDS). (If there is no house meetings, the report is to be discussed at each staff member's PDS).

Reports are to identify issues, progress, actions and updates against the DAS, EMR Annual Planner and the persons support plan (PCP), active support plan, health plan and behaviour support plan (if applicable).

The report must include notice regarding any training needs that have been identified and issues that may impact on the group home's operational management / or health and safety requirements. These are to be discussed with the Operational manager

Reports are submitted using the EMR DAS Keyworker report template.

**Key Functions**

**Some direct keyworker tasks include (but are not limited to) the following, as outlined in the DAS, EMR Annual planner:**

- Coordination of Person Centred Plan (PCP) Meetings, includes liaising with family, and other services
- Monitor and Action PCP outcomes and progress (Review Monthly opportunity and learning logs)
- Draft the PCP plan for resident endorsement
- Monitor individual health and arrange mandatory annual appointments such as Comprehensive Health and Management (CHAP), Nutrition and Swallowing assessments, Weight Monitor and any other specific health management reviews / protocols
- Plan, prepare and monitor the individuals active support plan
- Support the person to maintain or develop family and community networks / relationships, i.e. Support individual to have contact with their family, sending cards, calling, invitations to dinner

- Support the person to maintain, express and experience cultural expression
- Maintain with the person their information and ensure profile and other relevant information are current and up to date.
- Review individual communication tools, i.e. – communication dictionary or communication profile
- Maintain with the person their asset register and provide necessary support for personal purchases
- Maintain appropriate and professional communications / liaison with the persons day service and allied professionals
- Ensure that the persons personal needs are supported either by direct action or coordination / distribution of tasks to other group home staff
- Monitor, review and maintain appropriate supports
- Prepare, and submit monthly keyworker reports at house meeting and PDS
- Complete CERS in accordance with the Client expenditure policy
- Other: as per the Supervisors direction, i.e - portfolio responsibilities
-

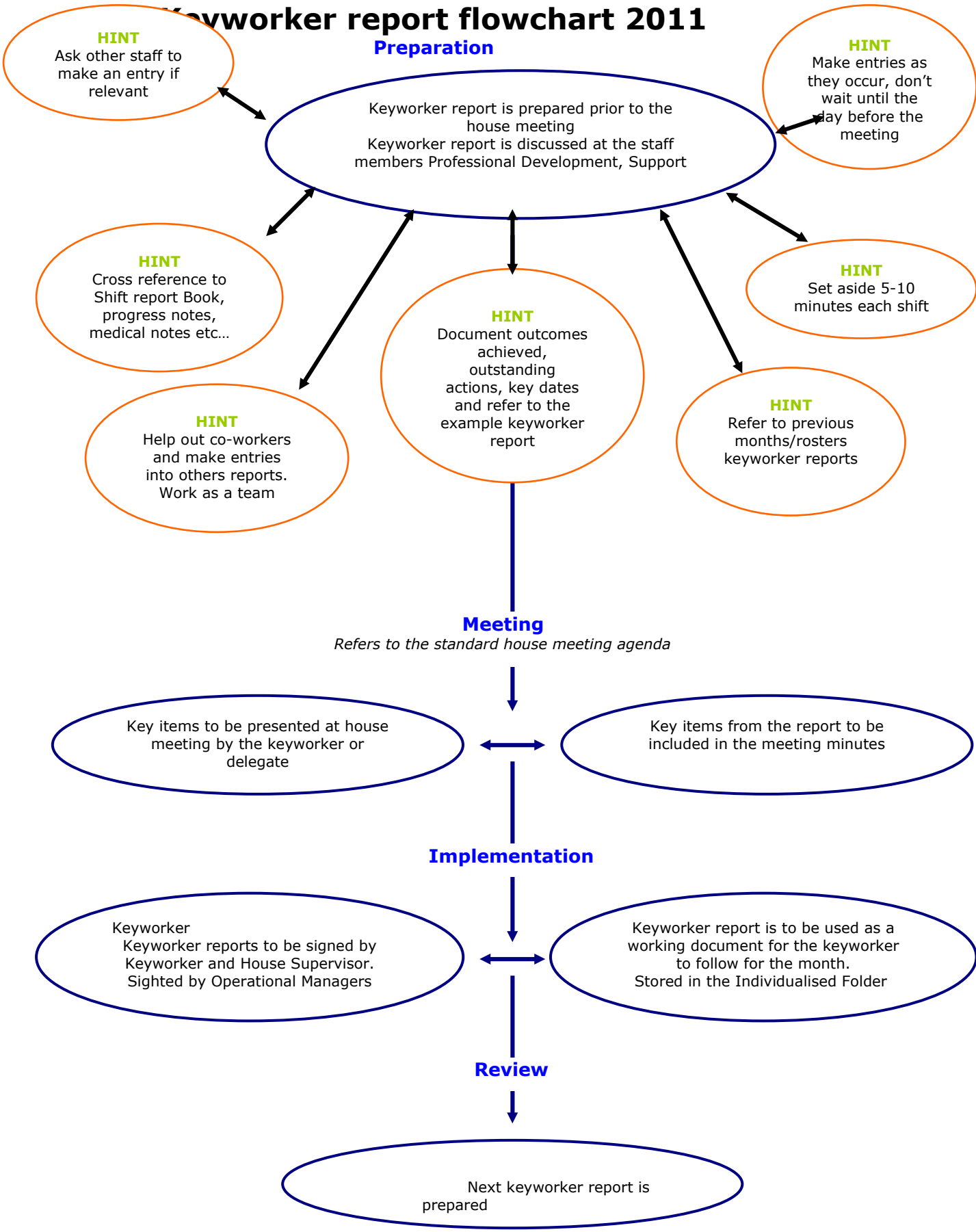
## Piecing the Puzzle together for the people that we support.....

An effective keyworker is one that takes the principles of the DHS Values, the Disability Act, and the Quality Framework and incorporates them in the role they have undertaken in supporting the person to met their personal goals and aspirations.

A good staff member is one who extends beyond the administrative functions of the role and provides real coaching, mentoring and advocacy for the persons who they are supporting.

The ideal keyworker is one that provides opportunities for personal growth and development, expression and choice and supports the person with a disability to have a valued role within their home and community.

# Keyworker report flowchart 2011



**Previous Keyworker report is then filed in each resident's Individualised Folder, Section 4**

# Rostered / Monthly Keyworker Report Summary 2011

☐Mr ☐Ms ☐Miss ☐Mrs **Address:** **EXAMPLE ONLY**

**Resident:**

**Month / Roster: / Year: 20**

| **Support Plan (PCP)**<br>Programs reviewed/required **Review Date: / /20**<br>**Goal updates:** | ***Action***<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| John is gardening every weekend and equip purchased | Incorporate in the PCAS Activity support plan |
| Have found a community gardening program. | Arrange to take John to activity to try |
| John is going on his ideal farming holiday next month | Commence writing list of what to take |
| John is cooking a meal of his choice every Thursday night | Feedback in learning log Expand-John can purchase items to cook |
| Johns goals are being progressed | Monthly opportunity and learning logs completed |
| Johns PCP meeting is due in May | Draft PCP and discuss with John who he wants to invite |

| **Person Centred Active Support Plan (PCAS)**<br>**Review Date: / /20**<br>Monthly Opportunity and Learning Log | **Action**<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| Staff are supporting John to follow the activity support plan | |
| John continues to do his washing and ironing, going really well | Review feedback-learning log, incorporate into PCAS |
| John is using the phone to call his mum weekly | Review learning log entries |
| But has trouble seeing the numbers | Contact Telstra to look into a phone with larger numbers |
| | |

| **Individualised Communication**<br>Personal Communication Dictionary **Review Date:23/6/2011**<br>*Communication System which the person uses.* | **Action**<br>*New communication methods e.g. Words/Keyword signs/Symbols /Gestures; the person uses or being exposed t this month.* |
|---|---|
| Who's on board-Community request cards | Used Community request cards, to order a coffee at the café |

| **Positive Behaviour Support (PBS), Behaviour Support Plans (BSP) or Supervised Treatment Order (STO)**<br>Details progress of strategies / supports, ind successes / barriers | ***Action***<br>***Details**: areas, items that require review, update or considera*<br>**Review Date:23/6/2011** |
|---|---|
| John's positive behaviour support strat current and effective | Ensure info is included in staff induction, John's routine |
| 15/03 Incident occurred, BMS in place, incident report completed | Incident incorporated into STAR chart recordings |

| | |
|---|---|
| | |
| | |
| | |

| **Day Service/Employment/Vocational/Volunteer**<br>*Details of communication, interactions, planning goals.* | ***Action***<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| 03/03 Contacted team leader to advise PCP meeting occurring in | Meeting time and venue to be confirmed |
| May | |
| John's comm. book is read through with him every night and | To continue to update every Sunday night |
| completed each Sunday with more pictures being used to | |
| make it interactive/meaningful for John | |

| **Family and Friends, advocacy contacts**<br>*Specific dates and activities.* | ***Action***<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| John continues to speak to his mum each Wed night | Will call Telstra to enquire into phone |
| 07 / 03 John visited his brother, had a great day | Assit John to plan for this catch up every 3 months |
| John has been invited to attend his friend Mary, 50th B'day on | To assist John to buy a present,confirm transport, support |
| 27/03 | |
| 17/03 John attended SUFY meeting | To read with John the minutes and schedule next mtg date |

| **Community Participation/Leisure/Holiday Options**<br>Specific dates and activities including day Service information.<br>What other opportunities would the person be interested in? | ***Action***<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| 03/03 John returned from his Sydney holiday | John wants to go again next year, note in PCP, report recieved |
| 05/03 John went to the local milk bar to buy bread and milk | by holiday provider, copy to sent to his mother |
| 21/03 John went to the local library and joined, had fun | John to be supported to attend fortnightly, noted in shift report |
| 25/03 Day services supported John to go to the Twilight zoo jazz | |
| 26/03 John attended the neighbourhood house mtg | John would like to continue to attend -2nd Tuesday of the month |

EXAMPLE ONLY

| Health and other Specialis<br>*If any section is Not Applicable to the person insert* **N/A** | | Action<br>***Details**: areas, items that require review, update or consideration* |
|---|---|---|
| Weight Monitor | **Ideal** 86.00 **kg**<br>**Current** 85.00 **kg** | *Required monthly. Entered into monitorin tool. Printout filed in Health & Wellbeing folder, Section 8* |
| Nutrition and Swallowing Issue Checklist (NASIC) | **Review Date: / /20** | Reviewed annually, 1 month prior to CHAPS |
| Comprehensive Health Assessment Plan (CHAP) | **Review Date: / /20** | Reviewed annually |
| Health Support needs summary | **Review Date: / /20** | 3mtly review, Annually with CHAPS |
| Medication Review | **Review Date: / /20** | Review 3 mthly, chemical restraint 4mthly |
| Detail specific health management plans: | **List:** | 3mtly review, Annually with CHAPS |
| Any serum/blood tests completed / required Epilepsy, full blood count, liver function, vitamin levels etc | **Type of checks:** | As determined by health proffessional; dependant on of test. |
| Dental Review | **Review Date: / /20** | Annually, in consultation with dentist |
| Oral Health Care Plan | **Review Date: / /20** | Annually, in consultation with dentist |
| Dental issues | **Review Date: / /20** | Annually, in consultation with dentist |
| Mental Health / CDDHV | **Review Date: / /20** | Minimum-Annually/ in line with BSP |
| Annual Specialist appointments | | |
| Podiatry: | **Review Date: / /20** | Determind by specialist and or CHAP |
| Optical: | **Review Date: / /20** | Determind by specialist and or CHAP |
| Occupational Violence Risk Assessment Mgmt tool: | **Review Date: / /20** | |
| Manual Handling Risk Assessment tool: | **Review Date: / /20** | |
| Other: | **Review Date: / /20** | |

| **CERS/Finances**<br>Items required, bills owing, asset register<br>**Financial Plan Review Date:30/6/2011**<br>**Asset register Review Date:1/4/2011** | ***Action***<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| All amounts owing for Johns holiday have been paid | John will need spending money taken out the day before |
| John now takes his money to buy his lunch on Wed and Fri | Ensure John has $10 on these days, written in shift report |
| John needs more funds for toiletries now that he requires | Include in next CERS review, being drafted for consult with |
| different t/paste | John, family and CERS officer, |
| | Assets register reviewed, next due May 2011 |

| **Other**<br>Such as resident issue, concern, current or emerging staff training needs to best support the person | ***Action***<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| John asked at resident house meeting to remind all to knock on | All to remember and prompt co-residents |
| his door when it is closed and wait until he answers | |
| | |

| | |
|---|---|
| | |

| **Complaints and Compliments**<br>Details and dates specific to this person. | ***Action***<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| 12/3 Letter received by mother thanking staff for organising | Entered into Compilments and Complaints folder |
| with John his holiday | |
| | |
| | |
| | |

| | | |
|---|---|---|
| Keyworker: | Signature: | Date:<br>**/ /20** |
| House Supervisor: | Signature: | Date:<br>**/ /20** |
| Operational Manager: | Signature: | Date:<br>**/ /20** |

# Rostered / Monthly Keyworker Report Summary 2011

☐Mr ☐Ms ☐Miss ☐Mrs **Address:**

**Resident:**

**Month / Roster: / Year: 20**

| **Support Plan (PCP)**<br>Programs reviewed/required **Review Date: / /20**<br>**Goal updates:** | ***Action***<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| | |
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| **Person Centred Active Support Plan (PCAS)**<br>**Review Date: / /20**<br>Monthly Opportunity and Learning Log | **Action**<br>***Details**: areas, items that require review, update or considera* |
|---|---|
| | |
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| **Individualised Communication**<br>Personal Communication Dictionary **Review Date: / /20**<br>*Communication System which the person uses.* | **Action**<br>*New communication methods e.g. Words/Keyword signs/Symbols /Gestures; the person uses or being exposed t this month.* |
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| **Positive Behaviour Support (PBS), Behaviour Support Plans (BSP) or Supervised Treatment Order (STO)**<br>Details progress of strategies / supports, ind successes / barriers | ***Action***<br>***Details**: areas, items that require review, update or considera*<br>**Review Date: / /20** |
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| **Day Service/Employment/Vocational/Volunteer**<br>*Details of communication, interactions, planning goals*. | ***Action***<br>***Details****: areas, items that require review, update or considera* |
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| **Family and Friends, advocacy contacts**<br>*Specific dates and activities*. | ***Action***<br>***Details****: areas, items that require review, update or considera* |
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| **Community Participation/Leisure/Holiday Options**<br>Specific dates and activities including day Service information.<br>What other opportunities would the person be interested in? | ***Action***<br>***Details****: areas, items that require review, update or considera* |
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| **Health and other Specialist reviews**<br>*If any section is Not Applicable to the person insert* **N/A** | | **Action**<br>***Details**: areas, items that require review, update or consideration* |
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| Weight Monitor | **Ideal kg**<br>**Current kg** | *Required monthly*<br>*Entered into monitoring tool*<br>*Printout filed in Health & Wellbeing folder Section 8* |
| Nutrition and Swallowing Issue Checklist (NASIC) | **Review Date: / /20** | |
| Comprehensive Health Assessment Plan (CHAP) | **Review Date: / /20** | |
| Health Support needs summary | **Review Date: / /20** | |
| Medication Review | **Review Date: / /20** | |
| Detail specific health management plans | **List:** | |
| Any serum/blood tests completed / required Epilepsy, full blood count, liver function, vitamin levels etc | **Type of checks:** | |
| Dental Review | **Review Date: / /20** | |
| Oral Health Care Plan | **Review Date: / /20** | |
| Dental issues | **Review Date: / /20** | |
| Mental Health / CDDHV | **Review Date: / /20** | |
| Annual Specialist appointments | | |
| Podiatry: | **Review Date: / /20** | |
| Optical: | **Review Date: / /20** | |
| Occupational Violence Risk Assessment Mgmt tool: | **Review Date: / /20** | |
| Manual Handling Risk Assessment tool: | **Review Date: / /20** | |
| Other: | **Review Date: / /20** | |

| **CERS/Finances**<br>Items required, bills owing, asset register<br>**Financial Plan Review Date: / /20**<br>**Asset register Review Date: / /20** | ***Action***<br>***Details**: areas, items that require review, update or considera* |
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| **Other**<br>Such as resident issue, concern, current or emerging staff training needs to best support the person | ***Action***<br>***Details**: areas, items that require review, update or considera* |
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| **Complaints and Compliments**<br>Details and dates specific to this person. | ***Action***<br>***Details****: areas, items that require review, update or considera* |
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| Keyworker: | Signature: | Date:<br>**/ /20** |
| House Supervisor: | Signature: | Date:<br>**/ /20** |
| Operational Manager: | Signature: | Date:<br>**/ /20** |