SUPPORT PLANNING POLICY AND PROCEDURES

The purpose of this policy is to outline the legislative requirements and practice procedures for undertaking support services for NDIS participants.

To comply with the requirements of NDIS Practice Standards and Quality Indicators. Compliance with the policy is a condition of appointment for all persons engaged in providing services on behalf of Full Care Lifetime.

To inform our team how to plan to collaborate in the development of the support plan that incorporates the participant's wants, needs and aspirations, including the type of Staff, time and length of the service linked to the registration group on their NDIS Plan.

POLICY

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

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

The Support Plan will provide transparent written information to the participant, detailing the services and type of support that they will receive from Full Care Lifetime. Where there is a change in the participant’s needs, preferences and goals, an amended Support Plan, with the help of participant’s feedback, will communicate this change in supports required to the participant.

Staff must be screened, trained and qualified in the roles that they undertake.

Support Planning Principles:

- The support planning process is consultative where the participant, family, friends, carer or advocate work together to identify strengths, needs and live goals with a focus on choice and decision-making.
- The participant’s preferences, values and lifestyle choices should be supported (wherever possible).
- Support Plans should promote the valued role of people with disabilities that is of their own choosing.
- Promotion of functional and social independence and quality of life.
- Support plans will contain goals.
- Service choices agreed to should reflect the participant’s personal goals.
- Support Plans should be creative, flexible and not developed by set patterns or methods of service delivery.
- Activities and supports in the plan must be inclusive of the participant’s chosen communities and maintain connections with their community to allow for active participation.
- If a participant identifies as Aboriginal or Torres Strait Islander, then their community will be contacted to allow for engagement and support services.
- The Support Plan is reviewed regularly (at least annually) and amended to respond to participant needs and preferences.

- Incorporate emergency response strategies for individual, provider, and community crises in support Plan
- Identify and document potential risks and response measures.
- Ensure clear protocols for safety, health, and wellbeing during emergencies.
- Establish communication plans, including emergency contacts.
- Train workers to understand and implement emergency procedures during induction.
- Regularly review and update emergency plans as needed.
- Obtain informed consent at intake for collecting emergency-related information.
- Align plans with legal and regulatory emergency requirements.
- Respect participant preferences while ensuring compliance.
- Document participant acknowledgment of the emergency plan.
- The Support Plan should be strength-based, seek to maximise independence, and build on the participant's existing networks.
- The Support Plan should be provided to the participant in their preferred language or in the preferred mode of communication, where appropriate and/or requested.
- The Support plan will be made available on site/participant's house for support workers
- Support Plan will also include the information for vaccination records, dental check-ups etc. which will be collected during the intake process.
- The participants or their advocates may request a review of the support plan at any time.
- Staff conducting support plan development will have the necessary skills and competence to undertake this function.
- Participants with a disability will also be facilitated to understand their NDIS plan, including:
    - Understanding and self-directing their NDIS plan.
    - Understanding the supports in their NDIS plan.
    - Funded support budgets.
    - Purchasing general funded supports.
    - Purchasing stated funded supports.
    - Managing and paying for their supports.
    - Choosing their providers.
    - Making agreements with their preferred providers.

Procedure

Support Plan Development

Planning

- Explain the Support plan development process for the participant.
- Arrange a meeting time with the participant and (if applicable) their advocate or family.
- Develop the Support plan with as much input, choice and decision-making from the participant as the participant wishes. Document the reasons (should a participant choose to have minimal input into their Support plan).
- Prior to meeting with the participant review: Participant's Intake Form, Participant's assessment information; any referral documents, and other relevant notes or data available that will assist in understanding the participant as an individual.

Providing Information to the Participant

- Emphasis the importance of the participant identifying their own personal goals and aspirations.

- Use the appropriate Support plan as a prompt to assist the participant in identifying areas were
- Full Care Lifetime services may help them realise their goals.
- Outline the prompts on the plan, including discussion of the participant's physical, emotional, spiritual, cultural, community, social and financial needs.
- Provide the participant with a clear understanding of their choices and service options available so that they can make informed decisions about their choices and priorities.
- Explain to the participant any information-sharing requirements with other parties.
- Provide the participant with examples or suggestions of how Full Care Lifetime services may be able to help them achieve their goals.

Facilitating the Development of Participant Centred Goals

- Work with the participant and their advocate(s) to identify their personal goals.
- Ask the participant to identify the types of help or assistance that would be most important to them.
- Help the participant to recognise their strengths and capabilities
- Transform the participant's goals into SMART Specific, Measurable, Attainable, Realistic and Timely)
    - Example Simple Goal: To be able to get the mail.
    - Example SMART Goal: To be able to walk to the mailbox each day by me to get the mail.
- Set a timeframe with each goal so that progress can be determined.
    - Example: To be able to walk to the mailbox each day without assistance to collect the mail. To achieve this by date.
- Use the participants expressed priorities, agreed actions and goals to develop their Support Plan.

Also, consider:

- The financial resource capacities and any limitations of Full Care Lifetime services or specific programs to be utilised.
- The capacities, expertise and appropriateness of current Full Care Lifetime staff to provide the services.
- The availability of specialised subcontracted staff or services (if applicable).
- Other services or individuals who will provide services (as designated by the participant).
- Any volunteer supports available.
- Determine with the participant how each goal will be measured so that progress can be recorded.
- Identify with the participant, any potential barriers to achieving their goals, and work out strategies to alleviate these barriers.
- Ask the participant to prioritise their goals if many goals have been identified. For each goal - list the actions, responsibilities, frequencies and the duration of services to be coordinated or supplied on behalf of the participant. Document all the information in the Support Plan.
- Identify all stakeholders (Participants, family, advocates, community engagement links, other services or agencies) that will undertake to help the participant achieve each goal, and document this in the Support plan.

Support Plan Delivery and Review

- Negotiate the specific days for services or support and document these in the Support plan.
- (Where possible) agree upon time ranges for the services to build a level of flexibility into the service roster. (e.g., start time of between 1 and 1:30 pm and 1hr of Domestic assistance).
- (If not yet finalised) negotiate service fees and record these in the participant Service Agreement and on the Support Plan.
- Ask the participant to sign the Support Plan to acknowledge their agreement with it.

- Agree on the criteria to evaluate the effectiveness of Full Care Lifetime service responses and document this in the Support Plan.
- Ensure all involved stakeholders have copies of the agreed Support Plan.
- Explain to the participant that the Director will monitor the progress of the Support Pan, but the participant may also request a review of the Plan at any time.