E.02 Service Access and Equity

1.0 INTRODUCTION/BACKGROUND

Mercy Services conducts a number of programs funded by diverse sources. Mercy Services overall mission states that we aim "*to provide holistic, proactive and inclusive service, in the spirit of our foundress, Catherine McAuley, to all those we support and work with both in the community and in a residential setting. In all our work we strive to provide compassionate, respectful, high quality and environmentally sustainable practices".* The mission and Values of Mercy Services mean that staff take a holistic and integrated approach which considers the breadth of a person's issues (e.g., physical, spiritual, psychological, cultural and social) and the context within which these issues could be addressed over time.

Mercy Services values and philosophy direct the organisation to respond to all those in need without discrimination. It is also true that specific services have their eligibility criteria and geographic boundaries defined by their funding source and unless other funds can be found there may be limited capacity for Mercy Services to address these issues except via referral.

2.0 SCOPE

This policy clarifies the eligibility criteria for a person to be accepted for a service from each of the Mercy Services programs. The process that a person follows in becoming a client is also set out in this policy. This policy applies to all Mercy Services programs and the workers within them.

3.0 POLICY STATEMENT

Services provided by Mercy Services will be promoted in a manner which ensures equity of access.

The services of Mercy Services are not denied to any person on the grounds of their gender, marital status, religious or cultural beliefs, political affiliation, particular disability, ethnic background, sexual preference, inability to pay, or circumstances of their carer.

Some services provided by Mercy Services have restrictive eligibility criteria set by the funding source e.g., age, geographical location, already receiving an equivalent service from another level of Government.

Where demand for services exceeds supply priority of access criteria are provided to enable open and accountable decisions on accepting clients. Unless required otherwise by funding bodies, such prioritisation will be on the basis of relative need.

Clients who reapply for services are assessed, with needs being prioritised.

Clients in receipt of complementary services are not discriminated against in receiving additional services.

To ensure clients are able to make informed choices Mercy Services will endeavour to provide information in a format suited to individual needs.

Coordinators review this policy and procedure with client consultation regularly.

4.0 PROCEDURES

4.01 Ensuring equity for people from disadvantaged backgrounds

The identified special needs groups for priority of service are:

- people of Culturally and Linguistically Diverse backgrounds;
- people of Aboriginal and Torres Strait Islander background;
- people suffering from Alzheimer's or related Dementias (particularly for access to aged care services);
- people with an intellectual or psychiatric disability;
- people with few supports;
- "Forgotten Australians" (e.g., former child migrants and people from the Stolen Generations);
- people from the criminal justice system
- people who are homeless or at risk of being homeless;
- people from the lesbian, gay, bisexual, transgender and intersex (LGBTI) community; and
- financially disadvantaged persons.

4.02 Eligibility requirements

As Mercy Services is funded to provide a range of different programs, a person's eligibility must be assessed on the basis of their relationship to the unique entry criteria of each program.

1. RESIDENTIAL AGED CARE (Singleton)

Residential aged care

Eligibility:
- ✓ persons 65 years and over for non-Indigenous people, and 50 years and over for Aboriginal or Torres Strait Islander people; and
- ✓ be assessed by the Aged Care Assessment Team (ACAT) before being eligible;

Entry process:
1. Contact: ACAT or My Aged Care 1800 200 422 to be assessed as eligible;
2. Director of Care (02) 6572 2499 can be contacted by either: (a) client/support person or (b) hospital discharge or other service provider; and
3. Director of Care will complete the intake forms with the client if there is a suitable vacancy or will offer the option of being placed on a waiting list.

2. HOME CARE PACKAGES *(formerly Community Aged Care Packages and Housing-Linked Care Packages)*

Hours: between 8:30am and 5:00pm Monday to Friday (limited

assistance outside these hours if required).

Service provided: This Australian Government funded program that provides supports to enable older people remain living in their home and participating in the community. The client can decide on what they want the funds of their "Care Package" spent, such as:

- ✓ access to socialisation;
- ✓ dressing/Undressing;
- ✓ personal grooming;
- ✓ laundry assistance/ironing;
- ✓ lawn mowing;
- ✓ light home maintenance;
- ✓ light housework;
- ✓ meal preparation;
- ✓ medication supervision;
- ✓ pet care;
- ✓ shopping;
- ✓ showering/bathing;
- ✓ transport to appointments (by arrangement); and/or
- ✓ many other options to maintain/improve the person's health and well-being.

Eligibility:

- ✓ persons 65 years and over for non-Indigenous people, and 50 years and over for Aboriginal or Torres Strait Islander people; and
- ✓ be assessed by the Aged Care Assessment Team (ACAT) before being eligible for a package; and
- ✓ client living in the Newcastle or Eastern Lake Macquarie Local Government Areas (LGA).

Entry process:

1. Contact: ACAT or My Aged Care 1800 200 422 to be assessed as eligible.
2. If ACAT approve the applicant for services ACAT will either: (1) refer the client to Mercy Services or (2) give the client an Aged Care Number for the client to contact Mercy Services/other providers.
3. A Coordinator will complete the intake forms with the client if there is a suitable vacancy or will offer the option of being placed on a waiting list.

3. COMMUNITY TRANSPORT *(see Home Support Program below)*

4. HOME SUPPORT PROGRAM

A range of services funded by the Commonwealth Home Support Programme (CHSP) to provide entry-level home support for older people who need assistance to keep living independently at home and in their community. These services were previously known as Home and Community care (HACC).

Hours: between 8:30am and 5:00pm Monday to Friday (limited assistance outside these hours if required).

Service provided: detailed in table below

Eligibility:
- ✓ persons 65 years and over for non-Indigenous people, and 50 years and over for Aboriginal or Torres Strait Islander people; and
- ✓ be assessed as eligible by the Regional Assessment Services via My Aged Care portal; and
- ✓ client living in areas as specified below

Entry process:
1. Applicants must contact My Aged Care 1800 200 422 for a phone and/or in-home assessment.
2. If My Aged Care approve the applicant for services the client will either: (1) be referred to Mercy Services by My Aged Care, or (2) My Aged Care will give the client an Aged Care Number for the client to contact Mercy Services/other providers.
3. Within three days of the referral being sent, a Coordinator must either accept or reject the referral. If the referral is rejected the client or My Aged Care can approach other providers.
4. Mercy Services has agreed to commence services within:
   - two calendar days after acceptance for high priority referrals;
   - five calendar days after acceptance for medium priority referrals;
   - ten calendar days after acceptance for low priority referrals.
5. The Coordinator will update the client's My Aged Care portal service delivery information within fourteen days after acceptance.

Service type	***Service sub-type***	***Details***
Domestic Assistance	General House Cleaning	For people living in in the Newcastle and Lake Macquarie LGAs.
	Unaccompanied Shopping (delivered to home)	
	Linen services	For people living in Cessnock, Newcastle, Lake Macquarie, and Maitland LGAs, providing the following laundered linen usually twice per week to clients who have incontinence: ✓ Sheets ✓ Pillow Cases ✓ Towels ✓ Draw Sheets ✓ Face Washers ✓ Kylie Sheets ✓ Feeders ✓ Absorbent bed pads (available in two different types and sizes).
Personal Care	Assistance with Self-Care	Operating between 7:00am and 8.30pm – seven days a week for people living in the Newcastle and Lake Macquarie LGAs providing personal care assistance with self-care tasks (can involve the use of

Service type	*Service sub-type*	*Details*
		lifters/hoists) in the home to a maximum of 15 hours per week to any one client. Service types include: ✓ Eating ✓ Bathing ✓ Toileting ✓ Dressing/undressing ✓ Grooming and hair care ✓ Getting in and out of bed ✓ Moving about the house ✓ Assistance with prescribed exercises ✓ Assistance with therapy programs
	Assistance with Client Self-administration of Medicine	Operating between 7:00am and 8.00pm – seven days a week for people living in the Newcastle and Lake Macquarie LGAs providing drop-in reminder and assistance with medications (tablets must be in a blister/Webster pack)
Social Support Individual	Visiting Telephone/Web Contact Accompanied Activities, e.g. Shopping	Operating weekdays 8:00am to 5:00pm with caring volunteers assisting with the following: ✓ Shopping with the client; ✓ Individual transport to appointments; ✓ Home visits and telephone calls; ✓ In-home respite care; ✓ Information and referral; ✓ Completing forms, bills, banking, etc.; ✓ Advocacy; and ✓ Pet care. Tighes Hill office assists people living in one of the following suburbs: *Adamstown, Adamstown Heights (Newcastle LGA), Bar Beach, Broadmeadow, Carrington, Cooks Hill, Fern Bay, Georgetown, Hamilton, Islington, Kooragang, Kotara (part of), Maryville, Mayfield, Mayfield West, Merewether, Newcastle, Stockton, The Hill, The Junction, Tighes Hill, Warabrook, Waratah, Wickham* West Wallsend office assists people living in the areas around: *Seahampton to the north, Wangi Wangi to the south, Glendale to the east and Wakefield/Awaba to the west – the area usually known as Westlake and Northlake.* Wallsend Carers office assists people living in: *Wallsend and surrounding suburbs.* Elermore Vale Community Centre office assists people living in: *Elermore Vale and surrounding suburbs.*

Service type	*Service sub-type*	*Details*
Social Support Group		Group activities at our centres and at community venues are provided to clients of all of our sites: • Elermore Vale • Tighes Hill • Wallsend • West Wallsend
Home Maintenance	Minor Home Maintenance and Repairs Garden Maintenance	*A Monday to Friday 8:00 to 4pm service for people living in Newcastle LGA and Bennetts Green, Cardiff, Charlestown, Dudley, Garden Suburbs, Gateshead, Highfields, Hillsborough, Kahibah, Kotara South, Macquarie Hills, Mt Hutton, Redhead, Tingira Heights, Whitebridge and Windale.* ✓ Regular lawn mowing (generally every two weeks between October-March and every three or four weeks between April-September) ✓ Light pruning to make area safe ✓ One-off rubbish removal/yard clean-up ✓ Changing light globes and tap washers ✓ Repairs to doors, gates, steps etc. ✓ Contracting with electricians, plumbers etc. to complete work that requires a licensed tradesperson.
Nursing		Covers Newcastle and Lake Macquarie LGAs between 8:00am and 4:30pm Monday to Friday (excluding Public Holidays) - *arrangements may be made to provide a service outside normal operating hours if there is a compelling need and resources are available.* ✓ initial assessment of clients and carer needs; ✓ referral to other community services; ✓ ongoing assessment and nursing management; ✓ wound assessment and management; ✓ basic foot care; ✓ continence management; ✓ monitoring of blood sugar levels; ✓ administration of insulin; and ✓ organising and education regrading medication. Referrals to Community Nursing can also come from Hunter New England

Service type	*Service sub-type*	*Details*
		Health.
Meals	At Home	A frozen meal home delivery service is available to people living the areas around *Seahampton to the north, Wangi Wangi to the south, Glendale to the east and Wakefield/Awaba to the west – the area usually known as Westlake and Northlake*
	At Centre	A main midday meal and dessert are freshly made and if notified we can accommodate cultural, nutritional, and other individual needs. Meals are provided at: • Newcastle Elderly Citizen's Centre – Monday to Friday • West Wallsend – Thursdays.
Transport	Direct (driver is volunteer or worker) Indirect (through vouchers or subsidies)	For people living in Newcastle and Lake Macquarie LGAs. Operates between 8:00am and 3.30pm Monday to Friday (excluding Public Holidays). Providing transport by bus or by car, taxis depending on the type of transport required, with some vehicles being wheelchair accessible. Services also extend to persons who have limited or no access to private transport and they have difficulties in accessing mainstream transport systems. Transport provided to/from: ✓ Doctors, specialist appointments ✓ Medical treatments ✓ Hospital visits ✓ Physiotherapy ✓ Group social outings ✓ Podiatry ✓ Group shopping
Flexible Respite	In-home Day Respite Community Access - Individual respite	Newcastle and Lake Macquarie LGAs
Centre-based Respite	Centre Based Day Respite	Providing a wide variety of physical and social activities which cater for the individual needs of our clients. This service also includes: ✓ meal provided at Centre based activities; and ✓ assistance with transport to activities may be available for people living within 5km of the Centre. Tighes Hill Centre operates Monday, Tuesday, Wednesday and Thursday from 10.00am until 2:30pm

Service type	*Service sub-type*	*Details*
		West Wallsend Centre operates operates Tuesday and Wednesday from 10.00 am until 2:30 pm.
	Community Access - Group	Both Tighes Hill and West Wallsend Day Centre offer group community access activities.

5. NATIONAL DISABILITY INSURANCE SCHEME (NDIS)

Hours: between 8:30am and 5:00pm Monday to Friday (limited assistance outside these hours if required).

Service provided: detailed in table below

Eligibility:
- ✓ Persons under 65 years; and
- ✓ Assessed as eligible by the National Disability Insurance Agency.

Entry process:
1. Contact the NDIS: 1800 800 110 for an assessment, budget and service plan.
2. Once approved for NDIS services the client can contact Mercy Services/other providers to find out if there is service capacity.
3. If there is a vacancy a Coordinator will complete the intake forms with the client.

NDIS Cluster	NDIS Support Items
Accommodation /Tenancy assistance	assistance with accommodation and tenancy obligations
Assistance in coordinating or managing life stages, transitions and supports	coordination of complex supports
	coordination of complex supports- higher intensity
	life/transition planning
	establishment of mentoring and peer support
	assistance with decision making, daily planning, budgeting
	assistance to integrate into school or other educational program
	specialised transport to school / educational facility / employment/community
Assistance with daily life tasks in a group or shared living arrangement	assistance in a shared living arrangement
	assistance with daily life tasks provided in residential aged care facility

NDIS Cluster	NDIS Support Items
Assistance with daily personal activities	assistance with self-care activities
	overnight monitoring of self-care – off site or on-site on call rate *(incl. One hour assistance if needed)*
	assistance with personal domestic activities
Assistance with travel/transport arrangements	specialised transport to school / educational facility / employment/community
	taxi and other transport fares beyond taxi subsidy taxi and other transport fares beyond taxi subsidy
	other transport fares
Community nursing care for high care needs	enrolled nursing care
	registered nursing care
Development of daily living and life skills	parenting training relating to disability
	group based training/skills development in daily personal activities
	group social skills development
	individual social skills development
	individual life and personal skills development
	numeracy, literacy, money/financial management skills development
	training for carers
	training in planning and plan management
	general life skills development activities
Early intervention supports for early childhood	specialised individual early childhood interventions
	specialised individual therapy for children with Autism
	specialised group early childhood interventions
Household tasks	assistance with the cost of preparation and delivery of meals
	house and/or yard maintenance
	house cleaning and other household activities
	linen service
Participation in community, social and civic activities	group based activities in a centre
	group based community, social and recreational activities
	assistance to access community, social and recreational activities
	development of skills for community, social and

NDIS Cluster	NDIS Support Items
	recreational participation
	community, social and recreational activity costs
Therapeutic supports	counselling as part of a group
	counselling for an individual
Training for independence in travel and transport	public transport training and support
Other innovative supports	

6. COMMUNITY CARE SUPPORT PROGRAM

These are similar to the HSP services described above and are available to former HACC clients who were assessed as ineligible for NDIS and "HSP type" services for younger people with a disability in areas that are yet to start/complete NDIS assessments.

Hours: between 8:30am and 5:00pm Monday to Friday (limited assistance outside these hours if required).

Service provided: Similar to NDIS and HSP as detailed above

Eligibility:
- ✓ Persons under 65 years with a disability; and
- ✓ Living in an area which has not yet commenced NDIS or was a HACC client with Mercy Services who was not approved for NDIS.

Entry process:
1. Contact NSW Family and Community Services, Information, Referral and Intake line: 1300 205 268
2. If there is a vacancy a Coordinator will complete the intake forms with the client.

7. SUPPORT COORDINATION PROGRAM

Hours: between 9:00am and 5:00pm Monday to Friday

Service provided: A Mercy Services case manager can assist people with a disability (or their carer) to access, pay for and organise supports to maximise their independence and meet their support/care/health/well-being needs. Assistance is also available with advocacy. The program is designed to assist people until such time as the area in which they live is covered by NDIS services and the individual receives an NDIS package.

Eligibility:
- ✓ Persons under 0 to 65 years with a disability; and
- ✓ Living in the Cessnock, Dungog, Lake Macquarie, Maitland, Muswellbrook, Port Stephens, Singleton or Upper Hunter LGAs - until such time as each LGA is fully covered by the NDIS scheme

Entry process: 1. Contact: Support Coordination Program (02) 4961 2686.

8. CARE COORDINATION PROGRAM

Hours: between 8:30am and 5:00pm Monday to Friday.

Service provided: A Mercy Services Case Manager can help you get the most out of your NDIS plan by assisting you to: be clear how the plan will meet your needs, identify service gaps, address difficulties that arise with your plan and negotiate with other services.

Eligibility:
- ✓ Persons under 65 years with a disability; who have an NDIS package which includes coordination of supports.

Entry process: 1.Contact: Support Coordination Program (02) 4961 2686.

9. McAULEY OUTREACH SERVICE

Hours: weekdays

Service provided: A professional counselling service usually through home visits assisting parents (clients) to:
- ✓ address their alcohol and/or other drug related issues;
- ✓ address health issues/needs of both themselves and their children;
- ✓ address child related issues;
- ✓ develop/maintain a healthy stable lifestyle for themselves and their children;
- ✓ set personal/child-related goals and work towards the realisation of these goals;
- ✓ link their family with existing services & support their continued, appropriate use of these services; and
- ✓ provide education and information regarding drug and alcohol, health and related issues.

Eligibility Criteria:
- ✓ Parents with children under 12 years where parental drug or alcohol use is affecting the family functioning; and
- ✓ Living in either the Newcastle, Lake Macquarie, Port Stephens, Maitland, or Cessnock LGAs; and
- ✓ The parent (potential client) wants to make positive changes in their life to benefit themselves and their families.

Entry process: New referrals: (02) 4961 2686
McAuley Outreach Service can generally inform people of the acceptance of their referral at the initial referral phone call. (Note also that McAuley Outreach Service has a 'no wrong door' approach that requires ease of access for people with a dual (MH & AOD) diagnosis in E.03 Meeting Individual Needs Policy).

10. McAULEY PARENTING PROGRAMS

Hours: weekdays

Service provided: The Family Support Worker provides general support to families through home visiting in the Newcastle/Lake Macquarie areas.

Eligibility Criteria:
- ✓ Families with children 0 to 8 years which have complex needs and are accepted by the Dept. of Community Services for their Brighter Futures program.
- ✓ Living in the Newcastle or Lake Macquarie areas.

Entry process: Newcastle / Lake Macquarie: *Samaritans Brighter Futures Team* (02) 40149360

11. HOLYOAKE PROGRAM

Hours: Groups arranged when demand is sufficient

Service provided:
- ✓ Relationships in Focus program – for anyone *(spouse, partner, parent, employer, care-worker, adult children, relative, friend)* who has been affected by another person's drinking, drug use and/or gambling.
- ✓ The Men's program & Women's program – 12 week program designed specifically to respond to either men or women who are experiencing problems with their use of alcohol or other drugs and/or gambling issues.

Entry process: Contact the Holyoake Coordinator: (02) 4961 2686.

12. BRIGHTON HOUSE

Service provided: Offers accommodation to men who are ready to take responsibility for their own recovery and sustain a drug free lifestyle in a supportive and friendly environment.

Eligibility Criteria:
- ✓ Male
- ✓ Committed to a 12-Step program of recovery which incorporates N.A. or A.A. meetings, one meeting per day for the first 30 days and then four meetings per week thereafter.
- ✓ The therapeutic community focus of Brighton House means that current residents make the final decision on whether a person is suitable to become a fellow resident. It is essential that the behaviour or conduct of any resident does not put at risk the recovery of other residents.

Entry process: Contact Housing Support Officer (02) 4927 5265 or Mercy Services Chief Executive Officer (02) 4961 2686

13. McAULEY COMMUNITY HOUSING

Service provided: Provides short to medium term (six months - two years)

accommodation.

Eligibility Criteria:

- ✓ Low income families who have been affected by substance abuse, and
- ✓ who otherwise are unable to obtain suitable housing through another agency.
- ✓ Priority is given to single parent families & families with special needs.
- ✓ Demonstrated ability to live drug & alcohol free for a significant period (at least six months) preferably having previously undertaken a rehabilitation program, with the motivation to help him/herself become a functional member of society.
- ✓ Accepting of appropriate support services.
- ✓ Acquired sufficient skills to care for his/her children and maintain acceptable standards of cleanliness and hygiene, with the capacity to pay rent and look after the premises**.**
- ✓ Commitment to a 12 step model of recovery and regular weekly attendance at AA/NA meetings.
- ✓ Commitment to the rules relating to McAuley Housing tenancies

Entry process: Contact: (02) 4961 2686

14. PRIVATE/SELF FUNDED SERVICES

Subject to the availability of resources any of the services may be provided to individuals, organisations and businesses. Such a request may be for a time-limited period *(such as when NSW Health broker a Compack (to prevent hospitalisation)* or maybe an ongoing service *(such as fortnightly cleaning or mowing)*. A request of private/self funded services will be made to the relevant Manager who will ensure that provision of the service will not compromise other services or place a strain on resources. The rates charges are detailed in the Mercy Services (E.04) Clients Fees policy.

Entry process: To determine if there is capacity to assist contact:
the Manager (02) 4961 2686 (for Newcastle LGA) or
the Manager (02) 49441944 (for other Hunter LGAs)

15. OTHER SERVICES – the Chief Executive Officer may establish new services with or without government funding for durations and with appropriate criteria and specifications.

4.03 Assessment

If a third party has referred a person for a service, the Director of Care/Coordinator (or delegate) will clarify with the potential client (or their Guardian) that they want the referral. The client will be offered the opportunity for their carer, a support person and/or their other services to be present at a face-to-face assessment.

Upon interviewing the client the Director of Care/Coordinator (or delegate) will consider the person's holistic needs and decide if these Mercy Services will:

- provide a service;
- provide a service in collaboration with another agency(s);

- make a referral to another agency for them to assist the person;
- not provide a service;
- place the request on a waiting list for an eventual service from Mercy Services.

If services are offered to a client on a temporary basis the client must be informed of how long the service will last and be informed in a manner that is clear to the client.

Various Mercy Services programs have specific assessment tools determined by their funding source or accumulated knowledge within the program (see (C.04) Program Performance and Monitoring).

During the assessment period the Director of Care/Coordinator (or delegate) will explain the details in the Client Agreement and Service/Care Plan. Where appropriate the Director of Care/Coordinator (or delegate) will also explain and give the client documents on Advanced Care Planning and the benefit of Enduring Guardian/Power of Attorney.

At McAuley Outreach Service the assessment process is considered to be completed when:

i) The assessment visits plus one occasion of service have been completed or
ii) There has been no response to our attempt to contact the client and the referrer has been contacted (if applicable). In this event the file is closed.

Personal Care clients will be assessed to determine their level of care:

i) High level – is a client who:
    1. requires two people to transfer using a hoist lifter, or chair/bed bound; and/or
    2. requires bowel care as per the Bowel Care Safe Work Practice; and/or
    3. requires a Bed Bath as they cannot roll themselves or move unassisted; and/or
    4. requires limb therapy as they cannot move their limbs; and/or
    5. requires assistance with showering due to a fatty apron that needs to be lifted; and/or
    6. has high risk rating on client risk assessment (Appendix 2); and/or
    7. scores 2 in the ONI functional profile section in relation to ability to walk, bath/shower, memory and/or behaviour.

ii) Low level – all other types of personal care

A Community Nurse/Occupational Therapist is required for high level personal care services.

An Occupational Therapist assessment is required when the Coordinator needs clarification of whether the client's home/equipment needs modification or when CCA tasks may need modification to suit the client's home/equipment.

4.04 Client risk assessment

a. Cautions

There is no evidence that says beyond doubt what factors predict client violence. This means Mercy Services workers need to be constantly vigilant for signs of frustration or aggression in clients.

Mercy Services is aware of the dangers of unnecessary, inaccurate or outdated client labelling. Mercy Services workers should be vigilant of inappropriate labelling.

A client rated as having a high risk is not automatically excluded from a service. Mercy Services will try to obtain appropriate levels of support for the client. If appropriate support cannot be found within Mercy Services, a referral can be made to an alternative agency for them to assist with part or all of the clients needs.

b. Risk Assessment/Management process

Client risk management follows the same Five Basic Steps as the work health and safety risk management process *(see also G.05 Risk Management Policy)*:

Steps	How this applies to Client risks
1. Identify risks to client, staff and/or other clients	☑ Director of Care/Coordinator *(or delegate)* identifies risks when a client is referred to Mercy Services, as needed and every year afterwards in areas such as: *1. Client (physical and emotional needs/limitations)* *2. Client home environment, if service may be provided there* *3. Public venues where service may be provided* *4. Vehicles and other equipment used in service delivery* *5. Hazardous substances used in service delivery.* ☑ Workers report risks when there is an incident/injury involving the client. ☑ Workers report when there is evidence of changes in the client's behaviour and/or circumstances.
2. Assess risks that may result because of hazards	☑ Director of Care/Coordinator *(or delegate)* completes an assessment of the risk posed by the client. Appendix 1, 2 or 4 may be used for this purpose if there is a need to clarify complex circumstances/risks.
3. Decide on control measures to prevent or minimise the level of the risks	☑ The Director of Care/Coordinator *(or delegate)*, in consultation with those who know the client well, determines the appropriate controls – following the hierarchy of: *1 Eliminate the hazard* *2 Minimise the risk* • *Substitute with a lesser hazard* • *Modify the work system or process* • *Isolate the hazard* • *Introduce engineering controls.* *3 Institute back-up controls* • *Implement administrative controls and safe work practices* • *Require the use of personal protective equipment.*

4. Implement Control measures	☑ Director of Care/Coordinator *(or delegate)* informs others of the risk and controls ☑ Director of Care/Coordinator *(or delegate)* to train/instruct worker and take other required action ☑ Worker to implement controls as set out by Director of Care/Coordinator *(or delegate)*
5. Monitor and review the effectiveness of measures	☑ Director of Care/Coordinator *(or delegate)* to ensure that workers follow the particular arrangements applicable to this client. ☑ Workers to give Director of Care/Coordinator *(or delegate)* information on the client's needs, behaviour and the effectiveness of interventions. ☑ Director of Care/Coordinator *(or delegate)* to regularly review assessment and Service/Care Plan or if an incident or change in circumstances necessitate a review.

c. Responsibilities

The Chief Executive Officer *(or delegate)* via regular file audits will ensure that Director of Care/Coordinators appropriately conduct risk assessments.

The Director of Care/Coordinator *(or delegate)* is to ensure that:

- ☑ risk assessments are conducted for all clients;
- ☑ the assessment is reviewed every year or when there is a significant change in the client's situation;
- ☑ file notes, Service/Care Plans, worker rosters, run sheets, communication sheets in client's home, relevant Safe Work Practices and/or if necessary Client Risk Management Plan be used to record and communicate the control measures to be used to respond to the client's needs/issues;
- ☑ workers assisting the client are aware of the client's issues and appropriate response *(e.g. colour coding, key words, details in Service/Care Plan/Job Sheet/roster).*

All workers are to:

- ☑ comply with service specifications stipulated in a client's Service/Care Plan etc.
- ☑ inform the Director of Care/Coordinator of any change (positive or negative) in the client's functioning or lifestyle that may change the assessment of client risk. If workers become aware that the Service/Care Plan and Client Risk Management Plan are unsuitable in meeting client need/risk they are to inform the Director of Care/Coordinator.

4.05 Allocation of workers

A worker is generally allocated to a client, based on:

- location of the client's home (for home based services);
- number and complexity of clients being assisted by available workers;
- the proximity of the client to other clients being seen by each worker;
- stated needs/wishes of the client;
- linguistic and cultural compatibility; and
- the worker considered best able to meet the client's needs.

The allocation of the worker will be reviewed with the Coordinator (or team – if applicable) as required.

4.06 Promotion of services

As a matter of justice Mercy Services wants those who are most in need of services to be aware of their eligibility for services.

- Promotional material will be developed in consultation with the Chief Executive Officer, printed in a clear and easy to read format (and when applicable will be available in different languages relevant to Mercy Services' CALD population).
- Material will be distributed through all major health and welfare agencies in the region.
- Mercy Services will monitor who is accessing its services, and the changing needs of the target population to ensure that the services provided are relevant and are not discriminating against any particular groups.
- Additional promotional and intake processes will be trialled if special needs groups are under-represented among clients.
- This planning and evaluation process is identified in detail in the Mercy Services C.4 Program Performance and Monitoring Policy.

4.07 Changes to Service Provisions and Re-assessment/Review Policy

When a person is accepted as a client of Mercy Services, this does not mean that they will be receiving the same type or level of service indefinitely.

Sometimes the client's circumstances change so that they need less or more service or a different type of service. Sometimes the particular program's circumstances change. It is essential then that Coordinator (or delegate) informs clients that, under certain conditions, services may change and assure them that they will be consulted when this happens.

Before and during such a reassessment/review the following requirements should be met:

- respectful attitude to client and attentive listening to what they say/how they behave;
- inform the client and, if appropriate, carers, family members or advocates about the need for the review and the change in circumstances leading to the review;
- ensure that the client etc. understands the needed changes, and agrees to them;
- inform the client of our commitment to refer them to other agencies that may be able to assist should our services not be able to satisfy their needs;
- Inform the client etc. that if they do not agree, that there is a right to appeal in line with our:
  - (E.01) Service Guarantee Policy;
  - (E.08) Complaints Handling policy;
  - (E.05) Client Participation, Decision-Making and Advocacy Policy;
- complete the reassessment and revised Service/Care Plan;
- follow the exit policy/referral to another agency policy where appropriate; and
- document the decision and its reasons in the client file.

4.08 If service is refused

If service is refused, the person who requested the service should be advised immediately giving reasons why the service will not be provided. These reasons should be consistent with entry criteria for each particular program. The Coordinator (or delegate) should make sure that the client understands the reasons for refusal and that this refusal will not affect their future access to a service.

Information should be provided on other available services and if appropriate a referral should be arranged.

Information should be provided on when, and in what circumstances the person could reapply for the service if they have declined the service or have been refused the service.

The person should be made aware of the Mercy Services (E.08) Complaints Handling policy.

4.09 Where the client is placed on a waiting list

It is very unusual for a Mercy Services program to maintain a waiting list as it can create false hope for the potential client and such lists become inaccurate very quickly. Where a waiting list is kept:

- the priority of access rating (High, Medium or Low) for the client should be recorded with their details to ensure that high priority clients are assisted first;
- the person should be advised that they are on a waiting list for a service, and if possible given an estimation of the approximate waiting time;
- information should be provided on alternative services available in the community, and a referral should be made if appropriate;
- the client should know that their case can be reviewed and that they can ask for a reassessment at any time if their circumstances change; and
- the client should be aware of Mercy Services (E.08) Complaints Handling policy.

4.10 Compliance

Compliance with this policy is being measured by:

a) Quarterly file audit by Manager shows that audited clients meet the relevant eligibility criteria with this policy (see C.4 Program Performance and Monitoring Policy).

4.11 Evaluation

The performance indicators for the evaluation of this policy are:

a) at least 90% positive ratings from Mercy Services clients in the biennial Satisfaction Survey; and
b) 90% satisfaction with the quality and completeness of client files found in quarterly file audits over a year.

5.0 REFERENCES

1. Current Issues	None identified
2. Australian Standards	None identified
3. Legislation	a) Disability Discrimination Act, 1992 (Cth) b) Sex Discrimination Act, 1984 (Cth) c) Ombudsman Act, 1974 (NSW) d) Racial Discrimination Act, 1975 (Cth) e) Anti-Discrimination Act, 1977 (NSW) f) Children and Young Person's (Care and Protection) Act, 1998 (NSW) g) Child Protection (Prohibited Employment) Act, 1998 (NSW) h) Commission for Children & Young Peoples Act, 1998 (NSW) a) Disability Inclusion Act, 2014 (NSW)
4. Professional guidelines	None identified
5. Codes of Practice	None identified

6. Codes of Ethics	a) Australian Association of Social Workers Code of Ethics http://www.aasw.asn.au/document/item/1201 b) Australian Psychological Association Code of Ethics http://www.psychology.org.au/Assets/Files/Code_Ethics_2007.pdf c) The Nursing and Midwifery Board of Australia. Registration Requirements http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx d) Integrity in the Service of the Church https://www.catholic.org.au/media-centre/media-releases/cat_view/10-organisations/38-national-committee-for-professional-standards e) Mercy Services Code of Conduct
7. Evidence	a) ADHC "Standards in Action" (2012) http://www.adhc.nsw.gov.au/__data/assets/file/0008/235970/ADHC_Standards_in_action_combined_250513.pdf b) ADHC Addendum to the Standards in action manual: Guide for services working with children and young people with disability and their families http://www.adhc.nsw.gov.au/__data/assets/file/0018/314406/Addendum_GuideServicesWorkingWithCYP-AH14-262062.pdf c) Addendum to the Standards in action manual: Women with Disability https://www.adhc.nsw.gov.au/__data/assets/file/0008/338948/addendum_standards_in_action_manual_women_with_disbility.pdf d) Home Care Package Guidelines (2014) https://www.dss.gov.au/sites/default/files/documents/08_2014/home_care_packages_guidelines_2014.pdf e) Commonwealth Home Support Programme Manual 2015 https://www.dss.gov.au/sites/default/files/documents/06_2015/chsp_programme_manual.pdf f) Commonwealth Home Support Programme Guidelines 2015 https://www.dss.gov.au/sites/default/files/documents/06_2015/chsp_programme_guidelines_-_accessible_version_29_june_5pm.pdf
8. Mercy Services Values	Justice, Respect, Care, Unity, Service

6.0 OTHER RELATED POLICIES

- A.01 Mission and Philosophy
- A.03 Code of Conduct (staff and volunteers)
- A.05 Reconciliation
- A.06 Pastoral Care
- C.01 Management Roles and responsibilities
- C.03 Operational Planning
- C.04 Program performance and monitoring
- C.05 Quality Improvement
- E.01 Service Guarantee
- E.03 Meeting Individual Needs
- E.04 Client Fees
- E.05 Client Participation, Decision Making & Advocacy
- E.06 Involvement of Families and Friends
- E.07 Behaviour Support
- E.08 Complaints Handling
- E.09 Client Records
- E.11 Coordination with other services
- E.13 Cultural Awareness
- E.17 Privacy
- G.05 Risk Management

- G.06 Safe Home Visiting

7.0 RELATIONSHIP WITH STANDARDS

Aged Care Accreditation Standards	*Home Care Standards*	*NSW Disability Standards*	*EQuIP Standards*
1.1, 1.2, 1.8, 2.1, 2.2, 2.4, 3.1,.3.2, 3.9, 3.10,4.1, 4.2	1.2, 1.3, 1.5, 1.6, 1.7, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 3.4, 3.5	1.1, 1.2, 1.3, 1.4, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9,2.8, 2.9, 5.1, 5.2, 6.2	1.1.1, 1.2.2, 1.6.3, 3.1.5

8.0 DOCUMENT CHANGES RECORD

Dates of change	*Section altered*	*Natures of changes made*
01/01/2005	All	First record of document
02/11/2009	All	Update format and content
02/12/2009	New 4.04 Risk Assessment	Section added to integrate former G.23 Client Risk Management Policy with this and E.03 Meeting Individual Needs Policy
25/05/2010	4.01.c	Change in Community Nursing hours
19/07/2010	4.01 and Appendix 2	Addition of Mercy Foster Grandparents Program
06/10/2010	Appendix 4	Updated
07/02/2011	a) 4.05 b) 4.08 c) 7.0 Standards	a) Addition of holistic assessment of client need including health promotion to assessment b) Clarified that this is not regular review and that respect is required c) Replace HACC and CACP Standards with Common Community Care Standards
06/02/2012	a) References b) Appendix 5 MOS Client	a) Added current issues b) Updated
04/06/2012	a) All sections b) 1.0 c) 4.01 d) 4.02 e) 4.03 f) 4.04 c g) 4.05 h) 4.06 i) 4.10 j) 4.11 and 4.12 k) 5.0 References l) Appendix 2	a) Staff/volunteer changed to worker and Program Co-ordinator changed to Coordinator b) Holistic care defined c) Remove DISI and changes to details of: Community Nursing, Community Transport, Domestic Assistance, Food Service, Home Maintenance, Linen service, Personal Care, all Social Support, Mercy Foster Grandparents. d) Additional groups added in line with changes to Commonwealth guidelines e) Delete requirement to always send a letter to client saying they are a client. Changes to reflect role of Community Care Access Point. Additional information on Mercy Foster Grandparents initial assessment. Reworded section on temporary services. f) Rosters and run sheets added to list of places risks and information is listed g) Replaced list of issues explained to client with requirement that Client Agreement and Care Plan be explained to client. h) Deleted requirement allocate workers to first client referred. Change review of worker to only as required. i) Reworded heading j) New sections k) Added Commonwealth HACC Manual l) Changes to Foster Grandparents and HACC paperwork
08/10/2012	a) 4.01.o b) 4.05b	a) Include ineligibility criteria b) New section clarifying PCS high or low care

Dates of change	*Section altered*	*Natures of changes made*
	c) Appendix 2 HACC	c) Specify that the functional assessment section must be completed and note that for PCS an OT assessment may be required
26/11/2012	All Sections	Organisation name updated
21/01/2013	a) Appendix 2	b) Inclusion of "Non-Response to scheduled visit" form for HACC and CACP services
07/07/2014	a) 1.0 Introduction b) 3.0 Policy Statement c) 4.01 Eligibility requirements d) 4.03 Initial assessment of applications e) 5.0 References f) 7.0 Relationship to Standards	a) include people from the Criminal Justice System b) Reword 7th paragraph c) Delete Foster Grandparents Program. Rename Aged Care Packages and consolidate former HACC services under HSP and add NDIS d) Delete Foster Grandparents program. Add details of RAS e) Updated Laws, Codes of Ethics and Evidence f) Added Aged Care Accreditation
03/02/2016	a) 1.0 Introduction b) 4.01 Procedures c) Previous 4.02 Ensuring equity for people from disadvantaged backgrounds d) 4.02 Eligibility requirements e) Previous 4.03 Initial assessment of applications f) Previous 4.04 Risk Assessment g) 5.0 References h) 6.0 Other related policies i) Previous Appendix 1 HACC Priority of Access j) Previous Appendix 2 Assessment Documents and material left with client	a) Updated and move people from criminal justice system to 4.01 Ensuring equity b) Reorder c) Reordered to now be 4.01 d) Updated list of NDIS Clusters and Support Items, remove Foster Grandparents program, add Residential Aged Care, Newcastle Community Transport, Newcastle Elderly Citizen's Centre, Wallsend Carers and Elermore Vale Social Support e) Most incorporated in new 4.02. Renamed Assessment f) Section deleted and content abbreviated into new 4.03 Assessment section g) Update Legislation, Code of Ethics, and Evidence h) Updated i) Deleted j) Deleted
05/10/206	a) 4.03 Assessment	a) Add Advance Care Planning etc
Review due 05/10/2019		

Appendix 1

Mercy Services - Community Transport Risk Assessment

Client Identification No.: **Date of Assessment:**

Client's carer will always travel with them: ❑ No ❑ Yes

Mobility aids used by the client: ❑ wheelchair ❑ walking frame ❑ walking stick ❑ other ……

Exit from home used by client: ❑ Front door ❑ Back door ❑ Side door ❑ Garage

Personal abilities, needs and characteristics	**Low risk**	**Medium risk**	**High risk**
1. Likelihood of request/conversation with client being unclear and inaccurate			
2. Client's ability to move independently from their home to the car/bus			
3. Client's ability to manage two steps if it is required on this journey			
4. Client's ability to manoeuvre in and out of a car/bus			
5. Client's ability to manage alone once at their destination			
6. Carer attendance and ability/willingness to provide all necessary help to client			
7. Client's ability to travel with a mobility or personal medical aid**			
8. Issues are raised by the reason for transport e.g., to/from medical treatment			
9. Likelihood of client's behaviour threatening or harming self or others			

"With help" is defined as any form of non-weight bearing physical assistance the passenger may require

** mobility or personal medical aid includes wheelchairs, walking frames and portable oxygen equipment but excludes walking sticks or other lightweight items

Permission granted for our bus to use the driveway at the client's home: ❑ No ❑ Yes

Pre-transport client home/site assessment required: ❑ No ❑ Yes

Driver completing client home/site assessment: ..... **Date:** .....

Safety around the vehicle	**Low risk**	**Medium risk**	**High risk**
Amount/type of traffic in residence's street			
Gradient and straightness of the section of road where the residence is located			
Parking outside the client's home			
Driveways ease to navigate, lack of obstructions, and of soundness of construction			
Safety and access in wet weather – *local roads not subject to flash floods*			
Safety of people from the house to the vehicle			
Ease of gates to open and go through			
Levelness of pathways used for transport			
Number and safety of steps and handrail			
Driveway/path solid and non-slip surface (concrete or pavers)			
Driveway/path free of any vegetation or any other obstructions			
Animals that may pose a risk			
Likelihood of problems if the driveway is shared by other residents			

Comments .....

Have any additional hazards been identified at first occasion of service? ❑ No ❑ Yes *(attach completed Hazard form)*

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CLIENT RISK ASSESSMENT FORM

Appendix 2

Client:..... **Source of Info**.....

What risk rating most accurately describes

		Likelihood			
		Very Likely: Known to routinely occur or very likely, given current circumstances or environment	**Likely**: Known to occur often or good chance will occur given circumstances or environment	**Unlikely**: Some potential to occur based on previous occurrences, or current circumstances or environment	**Rare:** No reason to believe this is likely to occur
Consequence	**Major** Life threatening or cause serious injury	**High**	**High**	**Medium**	**Low**
	Moderate Could result in temporary incapacity	**High**	**Medium**	**Low**	**Low**
	Minor Could result in inconvenience or first aid	**Medium**	**Low**	**Low**	**Low**

	Likelihood	Consequence	Rating	Comments *(incl. who might be harmed & in what way)*
1. Dangerous Behaviours				
a. Vulnerable to abuse b. Personality conflict with person c. Self harm/suicide risk d. Assault – physical or verbal e. Sexual – predatory f. Medications g. Wander, abscond h. Involuntary movements i. Falling, bumping, tripping,				
2. Antisocial Actions				
a. Gambling b. Alcohol /Drugs, c. Smoking d. Criminal activity				
3. Emotional & Cognitive Difficulties				
a. Confusion b. Unreliable memory c. Delusions d. Hallucinations e. Anxiety/panic attacks f. Depression g. Other mental illness				
4. Recurrent Medical Conditions				
a. Choking b. Seizures c. Respiratory conditions d. Allergies e. Skin conditions f. Diabetes g. Incontinence h. Other medical conditions				
6. Manual Handling				
a. Transfers b. Mobility c. Vehicle access d. Moving in bed e. Personal care tasks				
8. Other				

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SAMPLE CLIENT RISK ASSESSMENT QUESTIONS

	Likelihood	Consequence	Comments *(who might be harmed & how)*
1. Dangerous Behaviours			
a. Might this person be at risk of abuse or be taken advantage of by others?			
b. Might this person be at risk due to a previous conflict with Mercy Services staff/client?			
c. Might this person try to harm her/himself?			
d. Might this person be aggressive towards our staff?			
e. Might this person try to pressure others sexually?			
f. Might this person be unable to take her/his medications safely?			
g. Might this person wander or abscond?			
h. Does this person have involuntary body movements?			
i. Might this person fall, bump, or trip?			
2. Antisocial Behaviours			
a. Might this person have problem gambling if we go to a club with her/him?			
b. Is this person likely to be under the influence of drugs or alcohol when our staff are present?			
c. Might this person not stop smoking while our staff are present?			
d. Is this person engaged in criminal activity that could be unsafe for our staff?			
3. Emotional & Cognitive Difficulties			
a. Might this person get confused or misunderstand instruction from our staff?			
b. Can our staff rely on this person to accurately remember appointments and information?			
c. Might this person hold fixed false ideas about people/agencies in their life?			
d. Might this person describe voices and images that are not there?			
e. Might this person be unable to function due to Anxiety/panic attacks?			
f. Might this person be unable to function due to depression?			
4. Recurrent Medical Conditions			
a. Might this person be at risk of injury from choking?			
b. Might this person be at risk of injury from seizures?			
c. Might this person be at risk of injury from a respiratory condition?			
d. Might this person be at risk of injury from an allergy?			
e. Might this person be at risk of injury from any skin conditions?			
f. Might this person be at risk of injury from diabetes			
g. Might this person be at risk of injury from incontinence			
6. Manual Handling			
a. Could s/he or our staff be injured transferring this person?			
b. Could s/he or our staff be injured helping this person walking?			
c. Could s/he or our staff be injured helping this person in to or out of a vehicle?			
d. Could s/he or our staff be injured helping this person moving in bed?			
e. Could s/he or our staff be injured helping this person with their personal care tasks			
8. Other			

Client Risk Management Plan

Appendix 3

Step	Tasks	✓
1	Coordinator completes a Client Risk Management Plan (for High and Medium risks)	
2	Place a colour dot/tab (red, amber) in the "Risk Category" column to indicate the level of risk - see Client Risk Assessment Form	
3	Indicate the "Risk Area" recorded in the Client Risk Assessment Form	
4	Indicate the "Conditions" (Indicators/Triggers) that might result in the client's risk behaviour, as shown in the example below.	
5	Indicate how client risk can be eliminated or minimised in the "Prevention" column.	
6	Indicate the management and support plan to be implemented in the "Action Taken" column.	
7	Enter dates actions were or are to be implemented. Note date for future review.	
8	Communicate the assessment and management plan with all staff/volunteers who support this client	

Client name: …… . **Plan's author:** …….

Risk Category	Risk Behaviour	Conditions (Indicators/Triggers)	Means of Prevention	Management/Support Plan

Date form completed …… **Date review req'd** ……

M:\Shared\Forms & Letterhead\WHS Forms\ Client Risk Management Plan

Mercy Services
Example - Client Risk Management Plan

Step	Tasks	✓
1	Coordinator completes a Client Risk Management Plan (for High and Medium risks)	
2	Place a colour dot/tab (red, amber) in the "Risk Category" column to indicate the level of risk - see Client Risk Assessment Form	
3	Indicate the "Risk Area" recorded in the Client Risk Assessment Form	
4	Indicate the "Conditions" (Indicators/Triggers) that might result in the client's risk behaviour, as shown in the example below.	
5	Indicate how client risk can be eliminated or minimised in the "Prevention" column.	
6	Indicate the management and support plan to be implemented in the "Action Taken" column.	
7	Enter dates actions were or are to be implemented. Note date for future review.	
8	Communicate the assessment and management plan with all staff/volunteers who support this client	

Client name: .....Joe Citizen.....

Risk Category	Risk Behaviour	Conditions (Indicators/Triggers)	Means of Prevention	Management/Support Plans
	Falling Joe may fall out of his wheelchair. Staff might be injured picking him up	Wheelchair straps not secured correctly. Staff attempting to move Joe without assistance	Ensure Joe's wheelchair straps are secured and positioned as per Staff to use Safe Work Practices Referral to OT if it is apparent the wheelchair and/or fittings may be unsuitable Instruct staff not to move Joe on their own	Always two staff rostered to assist with Joe's personal care needs Ensure all new staff are trained in how to secure Joe in his wheelchair. Staff to use Safe Work Practices
	Aggression Joe has previously been verbally abusive and tried to punch staff when intoxicated	Only ever happened when he is intoxicated – usually around the anniversary of his car accident 15 March	Joe has agreed that staff will not stay and help him if he is intoxicated Joe has been referred for grief counselling but is unsure if he will continue with it.	Staff to tell Joe they can not stay if he is intoxicated when they arrive. Staff to phone Coordinator who will follow up with Joe before staff next work with him

Date form completed ……05 Feb 2009… **Date review req'd**……05 Feb 2010……

McAuley Outreach Service Client Risk Assessment Form

Appendix 4

Client: ……...…….. Client no. ……..…….. Person of potential risk: …….…….....

		Likelihood			
		Very Likely (VL) (Known to routinely occur or very likely to occur, given current circumstances or environment)	**Likely (L)** (Known to occur often. or good chance to occur given circumstances or environment)	**Some Potential (SP)** (Some potential to occur based on previous occurrences or current circumstances or environment)	**Rare (R)** (No reason to believe that this is likely to occur)
Consequences	**Major** (Life threatening or cause serious injury)	**High**	**High**	**Medium**	**Low**
	Moderate (Could result in temporary incapacity)	**High**	**Medium**	**Medium**	**Low**
	Minor (Could result in inconvenience or first aid)	**Medium**	**Low**	**Low**	**Low**

Interim Risk Assessment Date ……

Likelihood: **VL / L / SP / R** **Consequence:** **Major / Mod. / Minor** **Risk:** **Low / Med / High**

Follow-up risk assessment Date ……..

Likelihood: **VL / L / SP / R** **Consequence:** **Major / Mod. / Minor** **Risk:** **Low / Med / High**

McAuley Outreach Service Client Risk Management Plan

Client: ……...…….. Client no. ……..…….. Person of potential risk: ……..…….....

		Likelihood			
		Very Likely (VL) (Known to routinely occur or very likely to occur, given current circumstances or environment)	**Likely (L)** (Known to occur often. or good chance to occur given circumstances or environment)	**Some Potential (SP)** (Some potential to occur based on previous occurrences or current circumstances or environment)	**Unlikely(U)** (No reason to believe that this is likely to occur)
Consequences	**Major** (Life threatening or cause serious injury)	**High**	**High**	**Medium**	**Low**
	Moderate (Could result in temporary incapacity)	**High**	**Medium**	**Medium**	**Low**
	Minor (Could result in inconvenience or first aid)	**Medium**	**Low**	**Low**	**Low**

Interim Risk Assessment Date ……

Likelihood: **VL / L / SP / U** **Consequence:** **Major / Mod. / Minor** **Risk:** **Low / Med / High**

Follow-up risk assessment Date ……..

Likelihood: **VL / L / SP / U** **Consequence:** **Major / Mod. / Minor** **Risk:** **Low / Med / High**

Follow-up risk assessment Date ……..

Likelihood: **VL / L / SP / U** **Consequence:** **Major / Mod. / Minor** **Risk:** **Low / Med / High**

McAuley Outreach Service Client Risk Management Plan

Client (initials & no.) ……

Risk category	Risk behaviour	Conditions (Indicators/Triggers)	Prevention strategies	Support plan
1. Violence / anti-social behaviour (client &/or other person)	1. Risk of anti-social / violent behaviour in the presence of staff	1. Not taking medication 2. Domestic violence 3. Untreated mental illness 4. Inappropriately treated mental illness 5. Current use of AOD 6. Unexpected mental health episode 7. Significant incident involving client 8. Worker has made FACS or police report	Phone client prior to appt and check the following: (Tick those applicable) ☐ Anyone else in the home or likely to be present? ** ☐ Has client used drugs or alcohol ** ☐ Current mental health status of any-one present # ☐ Has anyone in the home used drugs or alcohol? # ☐ Has client taken his/her medication? # ☐ Any breaches of AVO? # ☐ Request that the likely offender is not present at the interview# ** Asked of all clients ranked MED or HIGH risk before every visit	(Tick items applicable) ☐ Refuse referral and refer on ☐ Discontinue service and refer on ☐ Decline to visit client at home ☐ Centre-based appointments ☐ Meet at other appropriate venue ☐ Two-person appointments ☐ Cancel current appointment and reschedule
2. Other				

1. At allocation an interim risk assessment is completed.
2. If risk is assessed at MED or HIGH, a risk management plan is completed clearly identifying the prevention strategies to be implemented; and a second risk assessment is completed; and the file is red-dotted.
3. Where client are re-assessed at MED or HIGH risk the strategies marked ** above will apply; also strategies marked #, if applicable, and any other strategies identified above.
4. If relevant circumstances change during the course of our intervention, another risk assessment is completed and discussed at a staff meeting or with the coordinator
5. Risk assessments of current clients will be reviewed with the coordinator at each case review session.

(N.B. For all clients rated MED or HIGH, there must be a phone call addressing the issues discussed above before appointments are attended; for clients rated LOW risk, a text message is sufficient)

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