Health Planning Procedures

Summary: The Health Planning Procedures describe how the person, and support workers, plan, document, implement and review the person's health and wellbeing needs in consultation with health professionals, and the person responsible or guardian.

Family & Community Services
Ageing, Disability & Home Care

Health Planning Procedures

Document name	Health Planning Procedures
Policy	Health and Wellbeing Policy
Version number	1.3
Approval date	January 2016
Policy manual	Health & Wellbeing Policy and Practice Manual, Volume 1
Approved by	Deputy Secretary, ADHC
Summary	The Health Planning Procedures describe how the person and support workers, plan, document, implement and review the person's health and wellbeing needs in consultation with health professionals, and the person responsible or guardian.
Replaces document	New procedures
Authoring unit	Contemporary Residential Options Directorate
Applies to	People who are being supported in ADHC operated and funded non-government accommodation support services.
Review date	2017

Version control

The first and final version of a document is version 1.0.

The subsequent final version of the first revision of a document becomes version 1.1.

Each subsequent revision of the final document increases by 0.1, for example version 1.2, version 1.3 etc.

Revision history

Version	Amendment date	Amendment notes
V1.0	November 2014	Replaces procedures outlined in the Health Care Policy and Procedures, 2012
V 1.1	January 2015	Amended to incorporate feedback
V 1.2	January 2016	Amended to incorporate feedback from consultation
V 1.3	June 2016	Amended to incorporate feedback from Districts

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1 Health Planning Procedures

1.1 Background

The ADHC Health Planning Procedures (the Procedures) embody the principles of legal and human rights found in the New South Wales Disability Service Standards (the Standards), the commitment to deliver culturally responsive services to Aboriginal and Torres Strait people under the Aboriginal Policy Statement (the Statement), and the person centred guiding principles of the ADHC Health and Wellbeing Policy.

The Procedures are a guide for supporting people with disability to exercise their rights and entitlements under the Standards and Statement. The Procedures describe how ADHC supports people to make health related decisions, and to direct their own health planning and management, under the guidance of their 'usual' General Practitioner (GP)[1] and other health specialists.

1.2 Application of the Procedures

The Procedures are a requirement for ADHC operated accommodation support services to follow when they are applying the Guiding Principles of the Health and Wellbeing Policy. ADHC funded non-government accommodation support services may adopt the Procedures, or develop their own.

1.3 Person centred health planning

This section relates to the Health and Wellbeing Policy Guiding Principles 1, 2, 7, 8, 9, 10.

Various tools and templates accompany the Procedures to assist the person, and support workers with health planning. In addition to health planning tools and templates, a range of person centred thinking tools are also suggested.

The blue boxes in the right hand margin refer to a specific health planning tool or template that can be used.

Tools and Templates

A gold box in the right hand side margin refers to a specific person centred thinking tool. Person centred thinking tools are part of the Lifestyle Planning Policy and Practice Manual.

Person centred thinking tool

Person centred thinking tools support the person to lead and direct their own health planning. The tools can be used to identify:

- when the person's health support needs change

[1] Medicare defines the person's 'usual' GP as: *'The GP (or a GP in the same practice) who has provided the majority of services to the patient in the past 12 months, and/or is likely to provide the majority of services in the following 12 months'.*

- how a decline in the person's general health and wellbeing can affect their independence
- the person's preferred treatment and health support
- how particular treatments can affect the person's lifestyle and wellbeing
- issues relating to family, social interactions, psychological or emotional wellbeing, or spiritual needs.

When using each tool and completing each step, it is important to involve the person as much as possible. Engaging with the person will assist:

- the person by giving them the opportunity to discuss their health and wellbeing goals, and what is important to them
- support workers to advocate for the person and gather information in a coordinated way
- health professionals to better understand the person
- with communication between support workers and significant others
- in determining what actions are needed and who is responsible.

1.3.1 Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people have significantly poorer health outcomes than other Australians. The traditional Aboriginal and Torres Strait Islander perspective of health is holistic, and encompasses land, environment, physical body, community, relationships and law. Health is connected to the social, emotional, and cultural wellbeing of the whole community, and the sense of being indigenous[2].

An Aboriginal or Torres Strait Islander person can be well supported if culturally sensitive and person centred approaches are employed during health planning in the following ways:

- use the person's communication profile to learn the best way of communicating information about the disease and its management
- understand the person's history and experiences, and difficult relationships, especially with hospitals
- ask how the whole-of-life view (life-death-life) affects health planning and management
- ask how and where the Aboriginal and Torres Strait Islander person would prefer to receive services
- record the name of the proper contact person to discuss health issues and provide consent

[2] Health Facts _Info Net – Health Status 2012

- determine which health issues or practices are sensitive or taboo and who to refer to if they are
- confirm whether the person or family would prefer to work with the health system through an Aboriginal Liaison Officer
- ensure that the person and family understand the health service options and how they can access them.

1.3.2 Culturally and linguistically diverse (CALD) people

The person and family or carer's cultural and religious beliefs about health and wellbeing should be established. Demonstrate respect and sensitivity to the person's culture by considering:

- the person and the family or carer's views about health and wellbeing
- the role of spiritual and religious beliefs in health and wellbeing
- how the person and the family or carer communicate, for instance, through an interpreter
- the person's own role in problem solving and decision making
- access to culturally appropriate health services.

2 Roles and responsibilities

This section relates to the Health and Wellbeing Policy Guiding Principles 11, 12, 13, 14.

2.1 Support workers

Support workers and health professionals play an important role in supporting a person to be healthy and well, however their roles and responsibilities are very different.

Support workers are not expected to diagnose or prescribe treatment for the person. The role of all support workers is to observe and monitor the person's health and wellbeing on a day to day basis. The health professional diagnoses, prescribes, applies and coordinates treatment for health issues. The role of support workers in health planning is to support the person to follow the prescriber's recommendations to maintain good health.

Two factsheets have been developed, one for support workers and one for the GP. The factsheet for GPs informs them about the roles and responsibilities of support workers. This knowledge can help a GP to tailor health advice and prescribed health actions. The factsheet for support workers informs them of the GP's role in health planning (see 'Other resources').

2.1.1 Health advocacy[3]

Support workers often need to promote and uphold the rights and interests of the people they support. This is called advocacy.

The role of support workers is to advocate for the person during a health appointment by helping the person to communicate their health concerns to the GP, and to ensure that the GP provides written advice about managing the health concern.

In the context of health planning with the person, health advocacy includes:

1. Support, by providing health information, encouragement and skill development to empower the person to self-advocate.
2. Assistance, by prompting the person to communicate their health needs and issues with health professionals. For instance, supporting the person during the health assessment to communicate what health treatment advice is working or not working for them.
3. Representing the person, by speaking up when the person's rights are violated and they are unable to do so for themselves. For instance, if the health professional does not engage with or provide adequate advice and support to the person during a health assessment appointment.

[3] Advocacy role adapted from Victorian Advocacy League for Individuals with Disability (VALID)

Note: Representing the person does not include making health decisions for the person. This is the role of the person responsible[4].

The following diagram is based on the person centred thinking tool the **Donut**. The donut outlines the various roles and responsibilities for supporting the person during the health planning process.

The centre of the donut, 'core responsibility', outlines key responsibilities of support workers in maintaining a person's health and wellbeing.

Donut

The middle section of the donut 'use judgement and creativity' contains a network for the support worker to access to help solve problems and provide direction, and when to refer matters of concern to line managers.

The outer circle of the donut 'not the support workers paid responsibility' outlines the role and responsibility of senior managers and others involved in health planning.

2.2 Decision making support and consent

People should be encouraged and supported to make decisions about who provides their medical and dental treatment. When people have the capacity to consent to receiving treatment, including changes to medications, they must be supported to do so.

See Decision Making and Consent Policy in the Lifestyle Planning Policy and Practice Manual for more information about capacity and consent.

2.3 The person responsible and consent

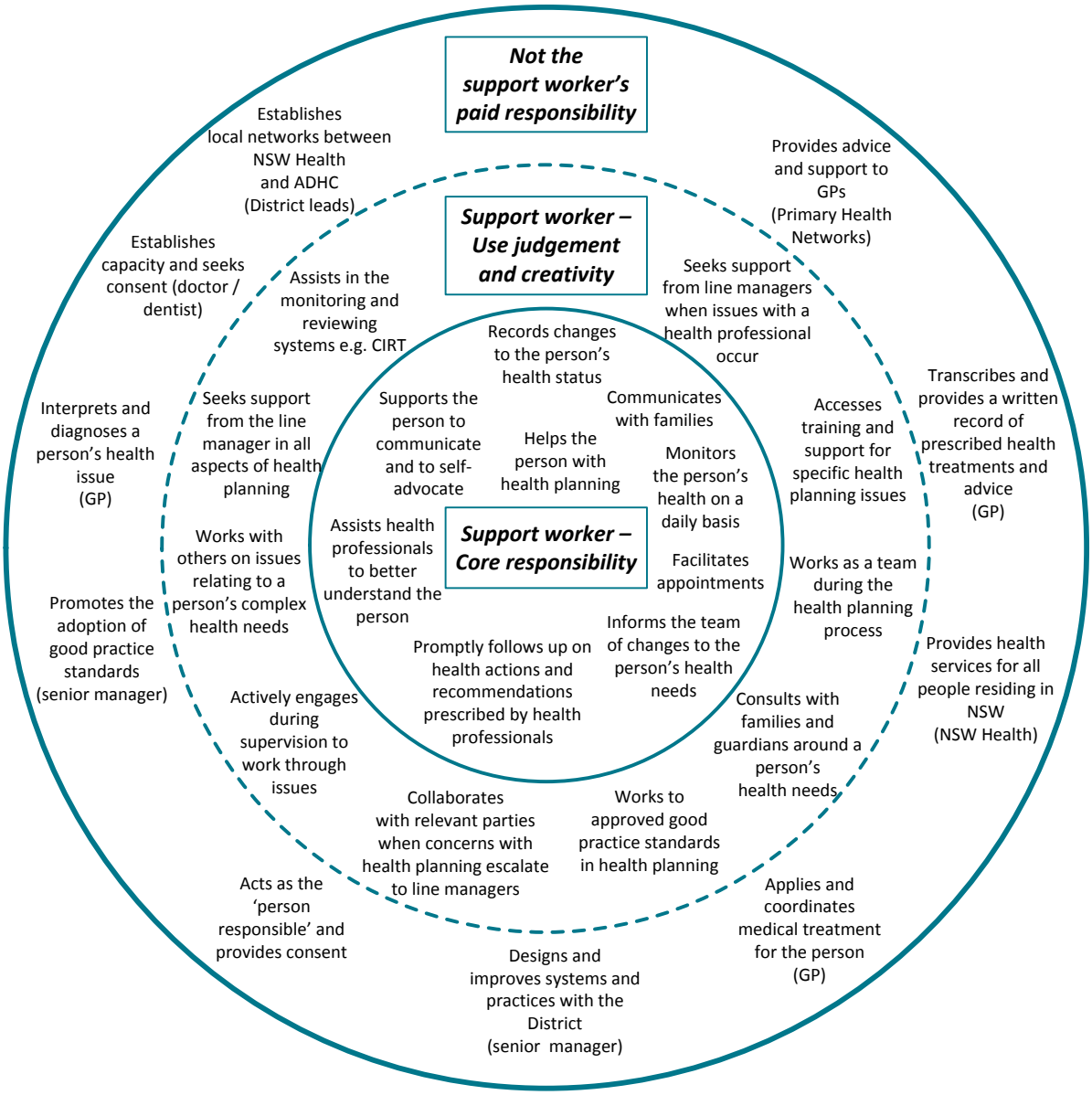
The treating doctor or dental practitioner is responsible for determining if the person is capable of understanding the general nature and effect of treatment and whether they are able to give valid consent. If not, and consent is required, it is given by the person responsible. The role of the person responsible is only relevant to giving or withholding consent for dental or medical treatments.

The NSW Civil and Administrative Tribunal (NCAT), Guardianship Division, provides guidance on who can be the person responsible for giving or withholding consent[5].

[4] NCAT Person responsible factsheet: http://www.ncat.nsw.gov.au/Documents/gd_factsheet_person_responsible.pdf

[5] NCAT Consent to medical and dental treatment fact sheet http://www.ncat.nsw.gov.au/Documents/gd_factsheet_consent_to_medical_or_dental_treatment.pdf

Diagram 1: Roles and responsibilities in health planning



2.4 Escalation strategy

If the outcome of a health appointment with a health professional is not satisfactory, the support worker will need to either approach the health professional or refer the matter to a line manager for further action.

At an unsatisfactory appointment the health professional may:

- refuse to provide recommendations in writing
- refuse to provide a copy of an annual health assessment
- not act on concerns raised about the person's health and wellbeing.

If the person, person responsible or support worker are not satisfied with the outcome of the health appointment, and have not been able to raise their concerns

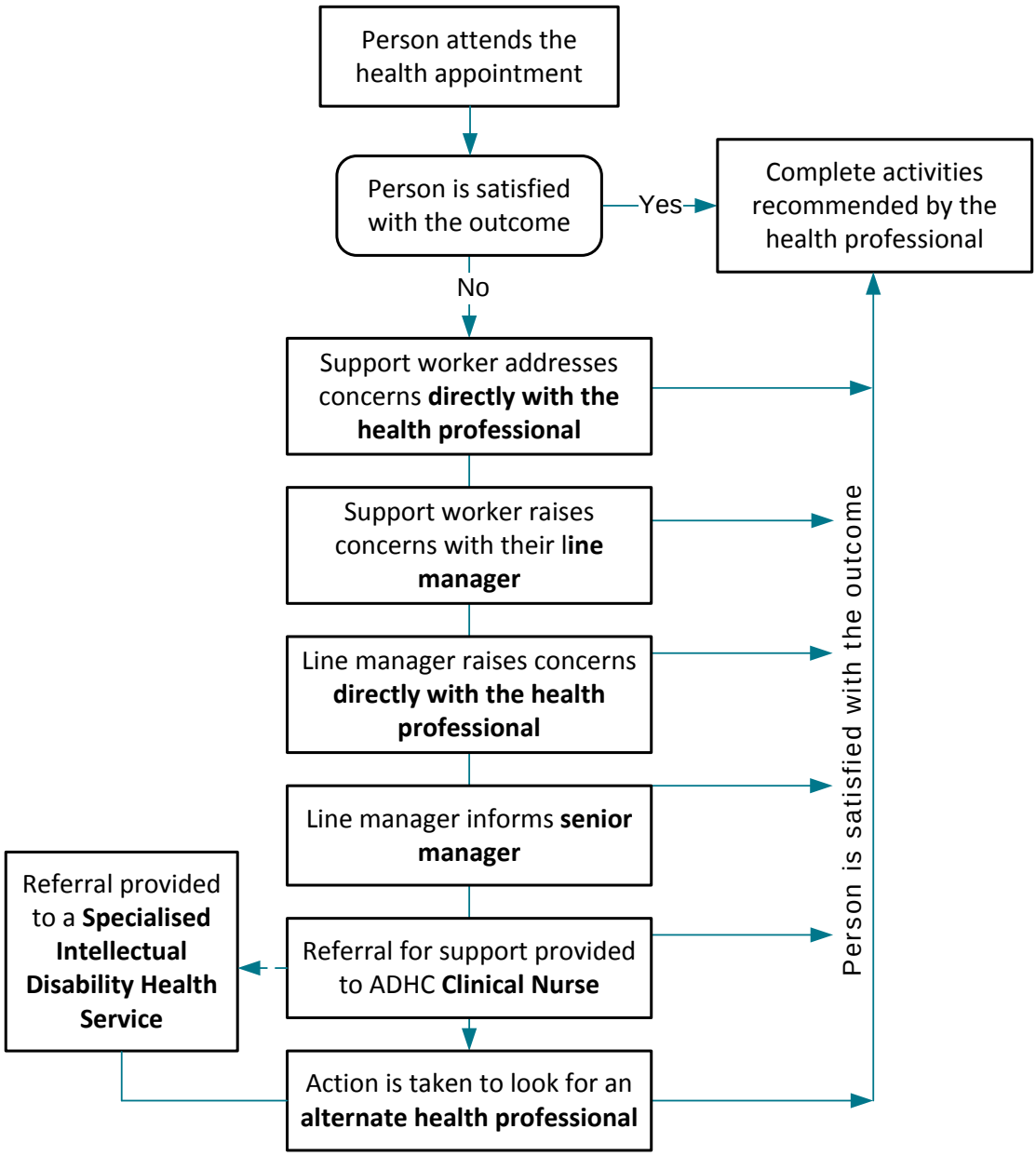
directly with the health professional during a consultation, the matter must be referred to the line manager for further action.

It is the line manager's responsibility to escalate the matter by:

- discussing the concerns directly with the health professional
- informing a senior manager of the issue
- making a referral to an ADHC Clinical Nurse for advice and support with approaching the health professional.

If the above strategies do not provide a satisfactory response from the health professional, the person has the option of looking for another who will provide a service that suits the person better.

Flow chart 1: The escalation strategy for unsatisfactory health appointments



When assisting the person to choose an alternate health professional the following factors should be considered:

- the person has an affinity with the health professional
- physical accessibility of the health professional for the person especially if the person has mobility issues
- the proximity of the health professional to where the person lives
- the health professional's knowledge of the disability sector and people with disability.

2.4.1 Specialist disability services

If the person is unwell or has complex health needs, action **must** be taken promptly. The person has the option of being seen by a Specialised Intellectual Disability Health Service for assessment.

A Specialised Intellectual Disability Health Service can provide a responsive course of action and provide advice and training in the area of disability to health professionals such as the person's GP.

Some Specialised Intellectual Disability Health Services will require a referral from a medical practitioner. Demand for specialist services may mean that the person is placed on a waiting list. If the person is put on a waiting list, the person and support worker need to seek advice from the person's GP or another GP on how to manage the person's health needs in the meantime.

3 My Health and Wellbeing Plan

This section relates to the Health and Wellbeing Policy Guiding Principle 3.

3.1 One comprehensive health plan

My Health and Wellbeing Plan

The comprehensive health plan used in ADHC operated accommodation support services is the **My Health and Wellbeing Plan**.

One comprehensive health plan integrates all current personal health, wellbeing and support needs, and health records for the person.

Benefits of an integrated health plan include:

- a format which assists and encourages the person to lead and direct their own health planning
- a document which is used everyday to record observations and changes in the person's health status
- a comprehensive document which can be taken to health appointments
- an easy source of information about the person for support workers and health professionals
- a medical and social history of the person to help inform future health and wellbeing decisions
- less repetition of information in different documents.

3.2 Application of the My Health and Wellbeing Plan

It is mandatory for ADHC operated group homes to have a My Health and Wellbeing Plan (the Plan) in place for every person.

Large Residential Centres and Specialist Supported Living can adapt the Plan by adding any additional documentation needed to meet the complex needs of the people they support, and the requirements of nurses' professional registration.

A person who accesses an ADHC operated centre-based respite service requires an up to date Respite Care Profile, and may choose to supplement it with components of the Plan.

A person accessing other ADHC operated accommodation support, in-home or drop-in support services may choose to have a Plan or use components of the Plan to capture their health and wellbeing needs.

The person's Plan is a living document which is used on a daily basis by the person and support workers.

The Plan should not be 'filed away' as this will discourage the person and support workers from using it. When not in use, the Plan should sit in a location where it is private and safe from damage or loss, but is physically accessible to the person,

support workers and others involved in supporting the person's health and wellbeing.

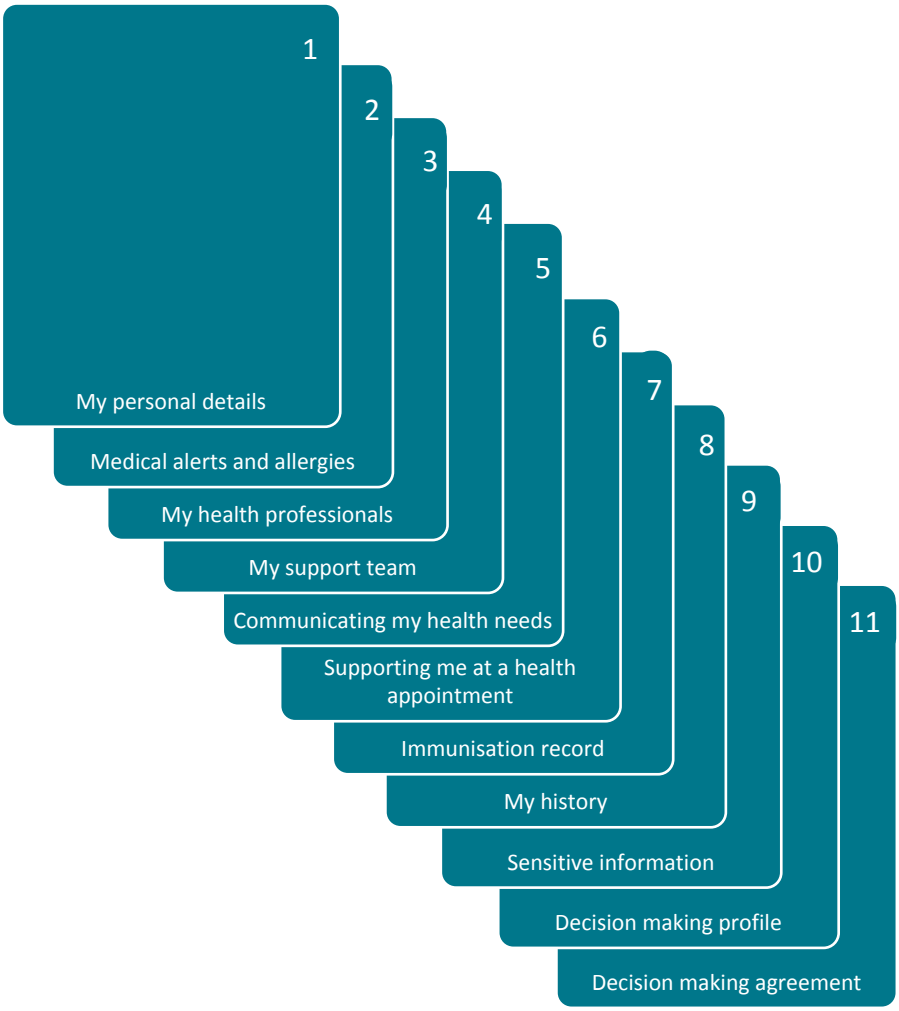
The Plan template is provided in the 'Tools and templates' section of the Health Planning Procedures as either a complete template incorporating Parts A to D. Alternatively the sections within each Part are also provided to assist in the ongoing review and recording of health and wellbeing information.

3.3 Part A – Information about me

Part A of the person's My Health and Wellbeing Plan contains all of the person's health and wellbeing details. It is developed from the person's perspective.

There are eleven sections to Part A as outlined in Image 1.

Image 1: My Health and Wellbeing Plan: Part A – Information about me



Part A is completed by the person and support workers who know the person well. In situations where the person is unable to provide personal details, the information is sourced from the person's records and from other people who know the person (Table 1 following).

Knowing the person well includes having a good relationship with the person, understanding the person's communication style and being an advocate for the person as necessary (see section 2.1.1).

If there are details about the person in Part A that are unknown, it is important to record this in the relevant section and to leave no fields blank. For instance if it is unclear if the person has received a Hepatitis B injection, then record 'unknown' in the person's **My Immunisation Record**. This information can be discussed further with the person's GP.

Immunisation record

Information in Part A is only recorded once, and if any changes to the person's details occur they are updated at the time or **as part of a quarterly review cycle** (see section 3.6 Part D – Review record).

Table 1: Sources of information about the person

Source	**Further information**
The person and the person's family	When requesting information from families, support workers are to be sensitive and respectful, especially if the person has an experience of trauma. Remember to be mindful of these sensitivities when asking questions about the person's medical and family history.
People who have known the person for a long time	Friends and advocates
Long term support workers	Support workers who currently or have previously supported the person
The Client Information System (CIS)	Discuss with your line manager about recording information on CIS.
Information about the person from files	People who have been with ADHC for some time, and who have received support from ADHC clinicians (psychologists, speech pathologists, occupational therapists, physiotherapists), may have a hard-copy file containing personal information. Discuss with your line manager about accessing information from these files.
eHealth[6]	eHealth is a record system which stores a person's health information online. The person has control

[6] http://www.ehealth.gov.au/internet/ehealth/publishing.nsf/content/home

Source	Further information
	over what information is stored and who has access to it. An authorised representative can be appointed if the person does not have the capacity to apply for and manage their eHealth record.
Archived information	Past documents relating to the person are stored in the Government Records Repository. If information is missing about the person it may be contained in archived records. Discuss with your line manager about whether it is necessary to access archived information.

The **My History** section is based on the Lifestyle Planning person centred thinking tool, **History Map**. It records significant events in the person's life which may impact on their health and wellbeing such as medical diagnoses, family medical history of relevance to the person and social history. The information in this section can be recorded in a table or as a diagram.

My History

History Map

The **Sensitive Information** section alerts the reader to whether the person has experienced a traumatic event in the past and provides a record of situations and/or actions to be avoided to prevent the person recalling the event. It is not necessary to record the details of the traumatic event. If there is more than one event, add extra pages. A referral can also be made to an ADHC Behaviour Support Team for support.

Sensitive Information

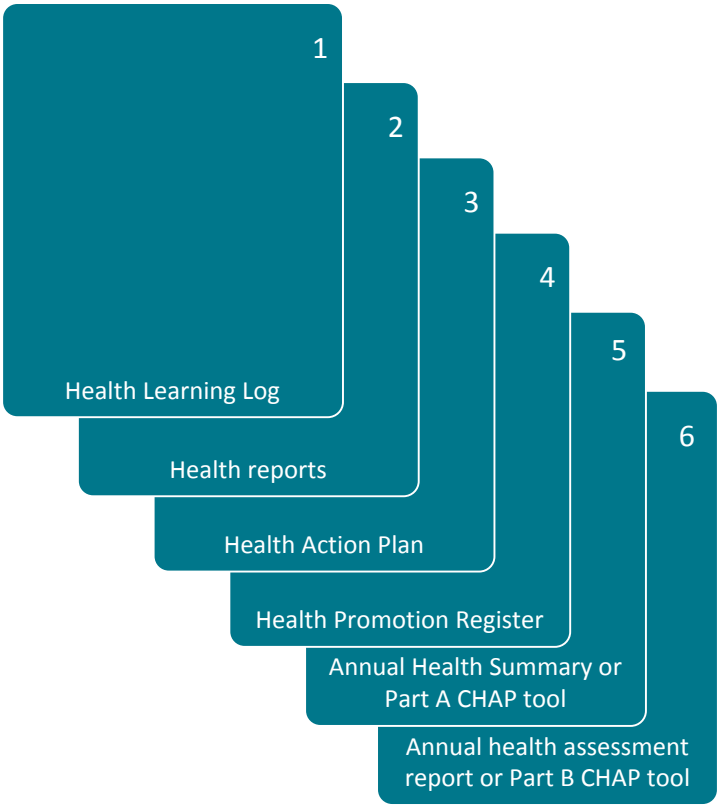
When completing the My History and Sensitive Information sections, care must be taken to preserve the person's and their family's right to privacy and confidentiality. It is good practice to check with the person's family before recording personal information, as the information may be private and confidential.

3.4 Part B – Information about my health

Part B of the My Health and Wellbeing Plan contains information on the person's current health status.

There are six sections to Part B as outlined in Image 2.

Image 2: My Health and Wellbeing Plan: Part B – Information about my health



Part B allows support workers to record and store information about the person's health and wellbeing.

All support workers who provide support to the person are responsible for keeping this section current and up to date. This includes permanent, temporary, casual and agency support workers.

3.4.1 Health Learning Log

The **Health Learning Log** is a tool used every day to record any observed or communicated changes in the person's health.

Health Learning Log

Recording health information in one place helps health professionals to understand what is happening for the person over time, and to identify indicators and patterns of ill health. It avoids the need to rely on one person's understanding or memory of the person's health issues.

The Health Learning Log also supports holistic health care as health professionals are made aware of treatments and prescriptions by other professionals.

It is the **responsibility of all support workers** to record changes in the person's health status in the Health Learning Log. This includes permanent, temporary, casual and agency support workers.

To determine whether a change in the person's health status has occurred, refer to:

- the person directly
- how the person communicates their health needs as outlined in Part A of the My Health and Wellbeing Plan
- other support workers on shift or at other services the person may have attended recently such as a day program or work place
- recent written records such as the person's daily notes/shift report, the Communication Book, and completed incident reports.

Observations of the person's health status are recorded in the Health Learning Log and changes promptly provided to a health professional for interpretation and action.

Any actions arising from a health consultation should be recorded in a health report prepared by the health professional (see section 3.4.2 – Health Reports). The action and follow-up from the health report is then communicated to other support workers:

- verbally during shift handover (if possible)
- by noting the information on the **Individual Shift Report** (for ADHC operated group homes)
- in the **Communication Book**
- in the diary if time frames and appointments are involved
- at the next team meeting
- in the Health Action Plan (see section 3.4.3).

Observations on what worked and didn't work at the appointment can also be recorded in the person's Health Learning Log. This information is then used to update the **Supporting Me at a Health Appointment** section of the My Health and Wellbeing Plan (see section 3.3 Part A – Information about me).

Support workers record the person's detailed health and wellbeing information in the person's Health Learning Log.

For example, if the person fell over and sprained their ankle:

1. Apply first aid and seek medical attention.
2. Complete an incident report[7] outlining the situation, how it occurred, follow up action and any recommendations to prevent reoccurrence.

[7] CIS incident form

3. Make observations of the injury and record these in the **Health Learning Log**.
4. Refer the reader to where detailed information has been recorded by entering this information in the person's daily notes/shift report. For example, 'Danny tripped on a rock and sprained his ankle when walking to the corner store. Danny went to see Dr Mathews. Refer to the Incident Report, Health Learning Log, GP's health report and Health Action Plan for detailed information and further actions required'.
5. Make references to any additional support requirements in the Urgent Matter Alert on the **Individual Shift Report**.
6. Update any new information in the person's **Communication Profile** and **Health Action Plan**.

A reference to the incident can be made in the daily notes and Individual Shift Report.

3.4.2 Health reports

The **Health Reports** section contains all advice and health information recorded during a health appointment or consultation with the person's health professional.

When the person requires medical attention or has a scheduled health appointment, the support worker must ask the GP or treating doctor to provide a written record of the issue, treatments and any actions that are to be taken.

A written record provided by the health professional will eliminate the risk of support workers transcribing and misinterpreting information.

Support workers are not responsible for recording the advice and recommendations provided by the health professional in any format.

A written record from the health professional can be hand written or typed and should outline:

- when the consultation occurred
- who conducted the consultation
- the reason for the consultation
- any diagnoses that are made
- written instructions of prescribed treatment
- further actions and recommendations.

The health professional can record information on their own template or in the **Health Appointment Sheet** template. It is not mandatory for support workers or the GP to use this tool. Give the GP the option of using this tool by providing a copy at the beginning of the consultation.

Health Appointment Sheet

If the health professional provides a hand written report, the support worker attending the appointment needs to go through it with the health professional to

understand it and ensure that it is legible and clear enough for other support workers to read.

The written record provided by the health professional is filed in the Health Reports section by date, with the most recent health report at the top.

3.4.3 Health Action Plan

The **Health Action Plan** is a tool to assist the person and support workers to keep track of the completion of actions prescribed by a health professional.

Health Action Plan

The Health Action Plan is **not** intended to be used to transcribe and record health information from a health professional. This is solely the responsibility of the health professional (see section 2 – Roles and responsibilities).

The Health Action Plan assigns responsibility, to complete or monitor the completion of actions, to a support worker within a set time.

Each action should have a time frame for completion. When an action is completed, the line manager initials and dates the entry to indicate that they have reviewed the completed action. This will ensure that heath actions are monitored and completed when due.

For instance, after the person's annual appointment with the neurologist, actions may be recorded as shown in the example of a Health Action Plan below:

Action	**Date and name of health professional prescribing the action (information provided on the Health report)**	**Who is responsible for completing the action**	**Date due**	**Progress**	**Date complete**	**Team leader signature and date**
Get pharmacist to repack Webster-pak® with new medication	1.7.15, Dr Sommerville	Elmo Peters	2.7.15	Complete	2.7.15	*A. Smith 16.7.15*
Book blood test to check Tegretol levels	1.7.15, Dr Sommerville	Cindy Jones	15.7.15	Complete	14.7.15	*A. Smith 16.7.15*
Get person responsible to sign Epilepsy Management Plan	Not applicable	Cindy Jones	2.7.15	Forms sent to Alan Hines. Waiting for return by post	In progress	

The Health Action Plan is reviewed regularly to ensure that time frames are not missed. Depending on the health action, a review could be needed every week until the action is complete.

The **Appointment Checklist** is a non-mandatory tool which provides guidance to the person and support worker when making health appointments.

It is designed to present the person's information to the health professional in a clear and coordinated way. The health professional can then make informed decisions on how to best meet the person's health and wellbeing needs.

Appointment Checklist

Where possible, a support worker, who knows the person and the person's medical history, attends the health appointment. With the person's consent, a family member, or someone else who knows the person well, may also attend the appointment.

Store completed Appointment Checklists behind the Health Action Plan to keep track of items recorded and review it quarterly or sooner if required.

3.4.4 Health Promotion Register

Health promotion activities are often a neglected area for people with disability. The **Health Promotion Register** outlines what healthy living and health screening activities have been implemented and / or need to be completed with the person. It is essential that this section is completed to help the person monitor their health on an ongoing basis.

Health Promotion Register

If there are details about the person's health in this section that are unknown, it is important to record this in the relevant section and to leave no fields blank.

For instance, if it is unclear if the person has received a vision check, record 'unknown' in the relevant field in the Health Promotion Register. This information is then discussed with the person's GP who will document any referrals or prescribed treatments during the annual health assessment.

It is good practice for people to have a completed **Physical Activity Checklist and Plan**. This tool assesses the person's level of physical activity and provides a record of actions to improve the person's fitness (see 'Tools and templates'). Any plan developed should be discussed first with the person's GP at the annual health assessment appointment or an allied health professional such as a physiotherapist or exercise physiologist.

Physical Activity Checklist and Plan

☞ Refer to the Health Promotion Guidelines in the ADHC Health and Wellbeing Policy and Practice Manual, Volume 2 for further information on health promotion and physical activity ideas for the person.

3.4.5 Annual Health Summary or Part A of the CHAP tool

The **Annual Health Summary** tool summarises the person's health information gathered over the year. The summary is used to inform the annual health assessment with the person's GP.

Annual Health Summary

The Annual Health Summary is divided into body systems, for example, sensory, muscular-skeletal, respiratory and cardiovascular. Each section outlines symptoms that may occur if there is a problem in that body system.

It is the responsibility of support workers to record the health issue that is communicated by the person or observed by support workers, not to interpret what it means. It is the role of the GP to determine what each health indicator may mean and recommend any action that is required.

If the GP prefers to use the CHAP tool, the support worker completes the first section of the CHAP tool **instead of** the Annual Health Summary and stores the completed document in this section.

CHAP tool

3.4.6 Medicare health assessment or Part B of the CHAP tool

This section contains the most recent annual health assessment report completed by the person's usual GP.

The health assessment is the primary source of health information in which the GP directs the person and support workers on what health and wellbeing actions are needed. It is used to assess the person's health status by:

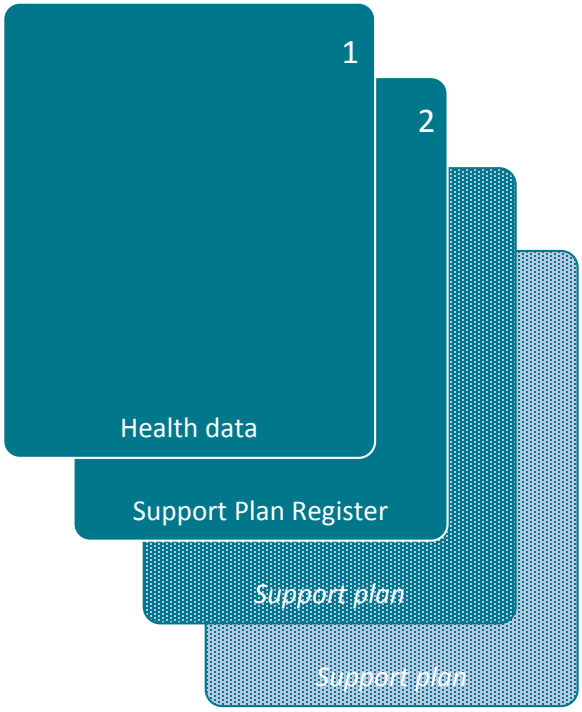
- gathering information about the person's current and long-term health and wellbeing
- identifying health risks
- recording diagnoses
- recording health information and advice
- recording actions and treatment regimes to manage current and long term health conditions
- recording changes to medication
- recording preventative health care actions
- placing the responsibility of health planning with the health professional
- providing a financial incentive to the GP with its completion.

3.5 Part C – My support plans

A support plan outlines treatment and support information to help manage a person's health condition. Depending on the health condition and the plan itself, a support plan may be prepared by the person and support worker, or the treating doctor.

There are three sections to Part C as outlined in Image 3.

Image 3: My Health and Wellbeing Plan: Part C – Health data and support plans



3.5.1 Health data

The **Health Data** section contains data sheets used to record information requested by the person's GP or health professional, to monitor an issue and better understand what is happening with the person's health.

It is the responsibility of all support workers to maintain the person's health data. This includes permanent, temporary, casual and agency support workers.

Weight Chart

This includes health data which may or may not have a support plan for a health condition such as a **Weight Chart**.

Each person requires a Weight Chart. It is mandatory for support workers to accurately record the person's weight at least monthly and height at least annually in the Weight Chart.

It is recommended good practice to maintain a **Menstruation Chart** where relevant for the person, however it is not mandatory (see 'Tools and templates').

Menstruation Chart

People with disability frequently require health support to maintain a healthy bowel. It is good practice to record a person's bowel action as a way of monitoring activity and detecting change from bowel habits that are normal for the person. Refer to the Bowel Care Guidelines in this Manual for information on how to monitor and support bowel health, the causes and risks of bowel dysfunction, and treatments. Use the **Bowel Chart** (see 'Tools and templates') to record bowel activity.

Bowel Chart

3.5.2 Support Plan Register

The **Support Plan Register** is a mandatory tool that must be completed as it records the support plans prescribed for the person by a health professional. The Support Plan Register also records when the person's plans are due for a quarterly review.

Support Plan Register

3.5.3 Support plans

Support plans are located in this section, behind the Support Plan Register unless support workers need to access them at certain places and times. For example, if a person is prescribed a Mealtime Management Plan, it may be kept in the kitchen for easy access when meals are being prepared and served.

The GP or treating doctor may choose to record support plan information and treatment recommendations in different ways.

For example:

- a written report
- a Medicare Chronic Disease Management Plan such as a GP Management Plan or Team Care Arrangement (see section 4 – Annual health assessment)
- a template developed by another health agency, such as the NSW Ministry of Health or the Australian Government Department of Health, e.g. Asthma Action Plan
- an existing ADHC support plan.

If the person's GP or health professional has developed a treatment or management plan for a health condition, the support worker supporting the person at the appointment must establish with the health professional when the plan is due for review and what outcomes should be expected from following the plan.

☞ For further information relating to specific health areas, refer to the procedures and guidelines for each area (in the Health and Wellbeing Policy and Practice Manual, Volumes 1 and 2).

3.6 Part D – Review record

There are two sections to Part D as outlined in Image 4.

Image 4: My Health and Wellbeing Plan: Part D – Review record

The person's My Health and Wellbeing Plan is reviewed and updated every three months or sooner if the person's health needs change.

Reviewing the My Health and Wellbeing Plan is essential for:

- monitoring and recording changes to the person's health
- highlighting any health patterns of concern
- reviewing the status of any aids or equipment that the person uses
- keeping track of the completion of recommendations and actions prescribed by the person's GP and any other health professional
- prompting support workers to record new information about the person and their health and wellbeing.

When reviewing the My Health and Wellbeing Plan, the person must remain the focus of the review. It is good practice to meet with the person first when reviewing the My Health and Wellbeing Plan. After meeting with the person, the support worker consults with the rest of the team to discuss changes to the person's health, and the My Health and Wellbeing Plan.

There are many opportunities for the My Health and Wellbeing Plan to be reviewed with other support workers on a regular basis.

Reviews occur during:

- Monthly supervision

Monthly supervision involves a formal discussion between each support worker and their line manager. Supervision includes a discussion about the person's

health and wellbeing needs and concerns, and actions the support worker is responsible for completing.

- Every team meeting

The person's health and wellbeing is a standard agenda item which is discussed at every team meeting. A sample **Team Meeting Agenda** is provided to facilitate discussion between the line manager and support workers at each team meeting (see 'Tools and templates').

Team Meeting Agenda

There are several Lifestyle Planning tools that are also of use, in particular, **Keeping the Plan Alive**, **Working / Not Working** and **Four + One Questions**. These tools help to maintain the focus of the review on the needs and wants of the person.

Keeping the Plan Alive

Working / Not working

A designated support worker must also communicate to other relevant parties if any changes to the My Health and Wellbeing Plan occur as a result of a review. This includes the person responsible and the person's place of work or day program. Consent must first be obtained from the person or family about what information is to be disclosed and to whom.

Four + One Questions

If any concerns or issues are raised during discussion with the person and other support staff, or if there is health information that needs clarification, consult with the person's GP or other relevant health professional.

Record any changes that have been made to My Health and Wellbeing Plan on the **Review Record** template. If there are no changes, record 'no changes'.

Review record

The line manager endorses the review and any changes made to the Plan by signing in the right hand column.

Date of review	Changes made	Initials of support workers completing the review	Line manager signature and date
17.11.15	Information provided in first draft of plan	LB, MR, MK	Annie James 17.11.15
15.12.15	▪ Added information to Part A Health professionals ▪ Updated information in Medication Support Plan ▪ New annual health assessment added to Part B	LB, MR, MK, PC	Annie James 15.12.15
1.2.15	No changes	LB, PC, MK, LM	Annie James 1.2.15

Part D also provides a record of the support workers who have read, understood and signed the My Health and Wellbeing Plan. Each support worker who supports the person must sign this section. This includes newly inducted staff, casuals and agency workers.

People who have read and understood the plan

Support workers who have difficulty understanding any aspect of the person's My Health and Wellbeing Plan must clarify the issue with the relevant line manager.

4 Annual health assessment

This section relates to the Health and Wellbeing Policy Guiding Principles 4, 5, 6, 11, 31, 32 and 33.

Each person living in an ADHC operated or funded accommodation support service (Group Home, Large Residential Centre and Specialist Supported Living) must have a health assessment completed every year. The responsible professional for completing the annual health assessment is the person's usual GP.

For all other ADHC accommodation support services, such as in-home support, support workers provide information to the person they support about their entitlement to have an annual health assessment conducted by their usual GP under Medicare.

4.1 Health assessment and tools

There are five Medicare health assessment items that the GP can use to assess the health and wellbeing needs of a person with intellectual disability (Table 2).

Each Medicare health assessment has a separate Medicare item number depending on the length of the assessment (see Medicare Health Assessment Factsheet in 'Other Resources').

Table 2: Medicare items

Medicare item	**Item number**	**Length of assessment**	**Frequency of service**
Medicare health assessment			
Brief	701	Not more than 30 minutes	Every 12 months
Standard	703	Between 30 and 45 minutes	
Long	705	Between 45 and 60 minutes	
Prolonged	707	At least 60 minutes	
Aboriginal and Torres Strait Islander people	715	Not specified	Every 9 months
Chronic Disease Management Program			
GP Management Plan	721	Not specified	Every 12 months
Team Care Arrangement	723		Every 12 months
Domiciliary Medication Management Review	900		Every 12 months

Medicare item	Item number	Length of assessment	Frequency of service
Mental Health Treatment Plan	2700, 2701 2715, 2717		Every 12 months
Individual Allied Health Services	10950-10970		Maximum of five allied health services in a calendar year

A **long or prolonged consultation is recommended** (item 705 and 707) as this allows adequate time for the GP to discuss any health and wellbeing concerns with the person, and how these can be managed.

The person and the GP may decide that a number of appointments are needed for the health assessment. For instance, the person may have two preliminary consultations with the GP to gather information, followed by a third prolonged appointment to undertake the Medicare health assessment.

As well as the Medicare Health Assessment tool, other health assessment tools have been developed for the disability sector. These assessment tools are based on the content of the Medicare Health Assessment tool. Examples are the Comprehensive Health Assessment Program (CHAP), and the assessment tool developed by the New England Division of General Practice. Whichever tool the GP uses, it must meet the minimum criteria outlined by Medicare.

In ADHC operated or funded accommodation support services, the annual health assessment appointment should be booked as soon as possible after the twelve months has elapsed (or 9 months if the person is Aboriginal or a Torres Strait Islander and the GP uses Medicare item 715).

Templates for the Medicare health assessments are available in the 'Tools and templates' and 'Other Resources' sections of the Health Planning Procedures.

4.2 Medicare's Chronic Disease Management Program

If the person has two or more chronic conditions and / or a terminal illness, the GP can manage their health needs under Medicare's Chronic Disease Management Program. The chronic disease Medicare items are additional to the Medicare health assessment items.

Under the Chronic Disease Management Program a range of support plans are available to assist the GP in coordinating the person's health care needs (Table 2).

Information on the Chronic Disease Management Program is available through the Australian Government Department of Health website[8].

[8] Medicare Chronic Disease Management Program

☞ Chronic disease Medicare items and the Chronic Disease Guidelines contain information about specific health conditions. These are contained in the Health and Wellbeing Policy and Practice Manual, Volume 2.

4.3 Aged care

Due to improvements in medical and social developments, people with disability are living longer. People with disability have the same aged related health concerns as the rest of the population however age related conditions may develop sooner[9]. Because of this, it is necessary for people who are ageing to access mainstream and specialist health supports to manage age-related health conditions.

Complex health needs are managed by the person's GP through:

- the Chronic Disease Management Program (section 4.2 above)
- referral to a health professional such as a Geriatrician who specialises in the health care of older people
- referral to an allied health professional to provide advice and support on daily living activities
- by referring the person to a Specialised Intellectual Disability Health Service (see section 2.4.1).

A referral to allied health services such as a physiotherapist or occupational therapist can assist a person whose physical health and mobility deteriorates by providing advice on equipment, home modifications and manual handling. Speak to a line manager about making a referral to an ADHC allied health professional or by contacting mainstream support services such as Independent Living Centres for advice on products and equipment to manage daily life[10].

If the person is 65 years or older and there is concern the person's accommodation setting does not provide the right support, discuss the options with the person or family. The person's needs may be met better in a specialist accommodation support service or aged care facility. With the person or family's consent, a referral can be made to the Aged Care Assessment Team (ACAT) who will assess eligibility for aged care services[11] with the person and family. The support worker can also discuss this option with a line manager.

Regardless of the age of the person, it is good practice to have discussions with the person and their family about the person's preferences for end of life care, rather than waiting for the person to be terminally ill and unable to be involved in the discussions. Refer to the End of Life Care Planning Guidelines in the Health and Wellbeing Policy and Practice Manual, Volume 2 for further information.

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[9] http://www.nswcid.org.au/health/se-health-pages/specialised-intellectual-disability-health-services.html

[10] http://ilcaustralia.org.au/products/search/advanced?major_code_id=5&minor_code_id=1254&q=

[11] http://www.myagedcare.gov.au/aged-care-homes/considering-aged-care-home

4.4 Women

The *Disability Inclusion Act 2014* recognises that "women with disability may face multiple disadvantages and are potentially more vulnerable to risk of abuse or exploitation"[12].

In supporting women with health planning:

- involve and encourage contribution by natural supports where the person wants this (natural supports are a protective factor in preventing abuse and exploitation)
- ensure supporters are chosen by the person such as allowing the person to choose female or male supporters
- ensure access to mainstream health services such as Women's Health Centres and Family Planning NSW for information and support with health promotion activities, reproductive health and sexuality
- ensure that information supports informed decision making and consent about general health and wellbeing, intimate relationships and self-protective strategies.

☞ Refer to the Health Promotion Guidelines, Decision Making and Consent Policy and Guidelines and the Sexuality and Relationship Guidelines.

4.5 Children

The *Disability Inclusion Act 2014* requires service providers to consider the particular needs of children and young people with disability[13] so that supports and services are provided in a way that:

- recognises the child or young person's right to live a life with full and active participation in activities which promote their health and wellbeing
- recognises that children and young people are more vulnerable to the risk of abuse and exploitation
- respects the views of the child or young person (with respect to their age and maturity)[14].

While all people under 18 years of age are regarded under the law as children, young people are given special consideration by the NSW Civil and Administrative Tribunal (NCAT) Guardianship Division. A young person can provide their own consent on a range of matters, or they can be assigned a public advocate by

[12] See Section 5(4)(a) of the *Disability Inclusion Act 2014*

[13] A child is any person 0-15 years of age and a young person is anyone 16-17 years of age. *Children and Young Persons (Care and Protection) Act 1998*

[14] See Section 5(5) of the *Disability Inclusion Act 2014*

NCAT if they need a legally appointed decision maker (refer to the Decision Making and Consent Policy and Guidelines).

The Maximising Health and Wellbeing for Children and Young People in Out-of-Home Placements Policy and Procedures provides guidance to support workers of ADHC operated and funded non-government accommodation support services on supporting and maximising the health, and meeting the medical and dental needs of children and young people with disability living in out-of-home placements. Refer to the policy and procedures to support a child or young person with disability with health planning.

Medicare's Child Dental Benefits Schedule (CDBS) enables access to basic dental services for children two to 17 years of age (refer to the NSW Ministry of Health for a list of services and eligibility requirements[15]).

Medicare also funds a number of initiatives for children with disability and their families to assist with assessment, diagnosis, and provision of early intervention services for eligible disabilities. For instance:

- a one-off assessment by a specialist or GP for early diagnosis and treatment of a range of conditions
- the Better Start for Children with Disability and Helping Children with Autism programmes to assist children under the age of six years and their families with accessing early intervention services.

Refer to Australian Government Department of Social Services for eligibility requirements, payment thresholds and information on the transition of these services to the National Disability Insurance Scheme[16].

4.6 Procedures for preparing and attending an annual health assessment appointment

The annual health assessment is a document used by the person and support workers throughout the year.

The information contained in the annual health assessment usually includes diagnoses, health information and advice, record of changes to medication and treatment regimes to manage certain health conditions (see section 4.2 – Medicare's Chronic Disease Management Program).

As support workers will often support and advocate for the person during the health assessment, it is good practice to prepare the information to be discussed with the GP before the appointment.

Each step involved with preparing for the health assessment appointment can be completed over a series of meetings between the person and support workers who

[15] Child Dental Benefits Schedule

[16] https://www.dss.gov.au/our-responsibilities/disability-and-carers/program-services/for-people-with-disability

know the person well. If the person consents, this can involve the family or person responsible. Refer to the steps below when preparing for and attending the annual health assessment appointment.

STEP 1: Review the current health assessment

This step involves reviewing actions and recommendations made by the GP from the last annual health assessment.

The person centred tool **Working / Not Working** is a useful tool to assess the effectiveness of health care actions and why previous actions were not achieved or completed, or did not appear to make a difference.

Working / not working

Any actions that have not been completed over the previous year are noted and discussed further with the person and others (see Step 6) and the GP at the person's health assessment appointment (see Steps 8 – 12).

STEP 2: Review the Health Promotion Register

Medicare's health assessment criteria outline a number of items to prompt a review of health promotion activities. For instance, hearing and vision health, men's and women's health and physical activity.

This step involves reviewing the person's **Health Promotion Register**, located in Part B of the My Health and Wellbeing Plan (see section 3.4.4 – Health Promotion Register).

Any fields that are out of date or 'unknown' are noted and discussed with the GP during the appointment. The GP recommends what actions are to be taken.

It is good practice to complete a **Physical Activity Checklist** and **Physical Activity Plan** with the person at this stage. The plan can then be discussed with the GP at the health assessment appointment. The GP may refer the person on to an allied health professional such as a physiotherapist or exercise physiologist.

STEP 3: Review the person's health data sheets

In this step, the information contained in the person's health data sheets is collated so that they can be discussed with the GP at the appointment (see section 3.5.1 – Health data).

The person's current height and weight is measured either before the appointment if they need to access specialised equipment or by the GP during the health assessment appointment.

STEP 4: Review existing support plans

The **Support Plan Register** located in Part C of the My Health and Wellbeing Plan records mandatory checklists and support plans, and support plans prescribed for the person by a health professional (see section 3.5 Part C – My support plans).

Support plans for the person are reviewed and updated in preparation for the person's annual health assessment.

They can include but are not confined to the person's:

- My Oral Health Plan
- Behaviour support plans
- My Eating and Drinking Profile OR Mealtime Management Plan OR Enteral Nutrition Plan
- Nutrition and Swallowing Risk Checklist
- Epilepsy Management Plan
- End of life care support plans.

Follow the review cycle and requirements in the procedures or guidelines relating to each support plan, and to section 3.6 of these Health Planning Procedures.

Any changes that are made to existing support plans are discussed with others (Step 6) and the GP at the health assessment appointment (Steps 8 – 12).

Changes to the person's **My Oral Health Plan** should be made by the GP during the health assessment or by the person's dentist at the person's annual dental review (see section 5 – Dental health).

STEP 5: Complete an Annual Health Summary or Part A of the CHAP tool

Annual Health Summary

The **Annual Health Summary** or **Part A of the CHAP tool** must be completed prior to the person's annual health assessment.

It is important that each body system in the Annual Health Summary is reviewed as some indicators of illness may be common to more than one body system for example, the skeletal, muscular or digestive systems.

If the GP prefers to use the CHAP tool, the support worker completes the first section of the CHAP tool instead of the Annual Health Summary.

The Annual Health Summary or Part A of the CHAP tool is completed by the person and support workers. If the person has difficulty with communication or chooses not to participate then it will need to be completed by support workers who know the person well.

After the Annual Health Summary or Part A of the CHAP tool is completed, review the information collected with the person, person responsible and, with the person's consent, others who know the person well. Record the people who were involved in completing the Annual Health Summary or CHAP.

STEP 6: Discuss the information with others

Four + One Questions

A useful person centred thinking tool for this step is the **Four + One Questions**. The tool guides the person and support workers with future health planning by reviewing and understanding the health actions that have been completed and any lessons that were learnt.

If the person is unable to or does not want to participate in a discussion about their health, others who know the person well need to be engaged in the process. They

will most likely include the line manager, other members of the team and, if the person is unable to consent, the person responsible.

If personal information is to be discussed with others, permission should first be obtained from the person if possible, to maintain the person's right to privacy and confidentiality.

Support workers often know a lot of important information about the person's health and wellbeing. Information sharing can occur in several ways, either individually with a line manager during monthly supervision, or in a group setting such as a team meeting. The team meeting is a useful environment for support workers to share different experiences and understanding of the person's health and wellbeing with other members of the team.

If the person has a chronic health condition, the line manager can place a referral for additional support from an ADHC Clinical Nurse. The ADHC Clinical Nurse may also be able to provide additional support to the person and support worker by speaking to the GP about the person's complex health support requirements at the annual health assessment appointment.

Any additional information about the person's health that is identified during discussion with others is recorded in the Annual Health Summary or Part A of the CHAP tool and discussed with the person's GP.

The person's consent is required for the health assessment[17]. If the person is not able to provide consent, consent from the person responsible is not required unless the person is objecting or, a minor treatment is to be performed at the time of the assessment, for example, a blood test. In this case, the GP must obtain consent for the treatment from the person, or person responsible.

STEP 7: Make an appointment with the person's GP and dentist

Use the **Appointment Checklist** tool to guide actions when making the health assessment appointment.

An appointment with a public or private dentist for the person's annual dental review is made at this stage if possible.

If the person attended a Public Oral Health Service Referral Centre within the last year an appointment may have been made for the next annual dental review. Look in the person's records such as the My Oral Health Plan or call the Public Oral Health Service Referral Centre and confirm if an appointment was made (see 'Other resources'). If not, make an appointment as soon as possible.

The person may also be eligible to receive a Public Oral Health Service through a private dentist registered under the NSW Oral Health Fee for Service Scheme (OHFFSS). Refer to the NSW Ministry of Health[18] or the 'Other resources' section of these Procedures.

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[17] NSW Civil and Administrative Tribunal (NCAT) Fact Sheet – Consent to medical and dental treatment http://www.ncat.nsw.gov.au/Documents/gd_factsheet_consent_to_medical_or_dental_treatment.pdf

[18] OHFFSS

STEP 8: Attend the appointment

The person must attend the health assessment appointment. The GP cannot perform a comprehensive health assessment if the person is absent.

If the person is physically unable to attend the appointment, request that the health assessment appointment occurs at the person's home at a time suitable to the person.

Remind the GP that the purpose of the appointment is for an annual health assessment, and that it is a long or prolonged consultation.

Provide the GP with the 'People with intellectual disability - Information for GPs during health assessments' Fact Sheet ('Other Resources').

Inform the GP that a copy of the health assessment containing a written record of the recommended treatment and actions will be required.

STEP 9: Use the Health Assessment Criteria

The **Health Assessment Criteria** tool lists the Medicare criteria. It is not a mandatory tool, and is designed for support workers to help them involve the person during the appointment, and to guide the discussion with the GP about the person's health and wellbeing concerns.

Health Assessment Criteria

Regardless of what health assessment template the GP decides to use (e.g. Medicare health assessment or CHAP tool), it is the responsibility of the attending support worker to ensure that all the criteria outlined by Medicare are discussed during the appointment.

If the GP is using the CHAP tool or the assessment tool developed by the New England Division of General Practice (see section 4.1), all sections in those tools need to be addressed.

STEP 10: Discuss the person's current health issues

Provide the information collected during Steps 1 through to 6 to the GP for their consideration.

That is:

- the information collected in the Annual Health Summary or Part A of the CHAP tool. Any body system that has been checked in the Annual Health Summary must be discussed with the GP during the health assessment appointment and noted in the far right hand column of the form,
- the outcome of actions completed or not completed from the last health assessment and previous health appointments,
- the person's My Health and Wellbeing Plan. In particular the person's:
  - history
  - immunisation status including missing vaccination records
  - Health Learning Log
  - health data

  - previous treatment plans
  - Health Promotion Register (including the Physical Activity Checklist and Plan)
  - reviewed and updated support plans
  - other relevant health professional reports that the GP may not have received.
- medication chart, medication record and medication profile.

If the person has not attended a Public Oral Health Service before and is eligible for the service, a referral will be required. The referral should be discussed and obtained from the person's GP at the time of the health assessment appointment.

STEP 11: Discuss the person's chronic health conditions

If the person has a chronic health condition or disease, now is the time to discuss the need for additional support from Medicare's Chronic Disease Management Program (see Section 4.2). This will depend on how complex the person's health and wellbeing needs are and is determined by the person's GP or other health specialist.

If the GP indicates that the person's chronic disease or long-term health condition is not being effectively managed, the GP may decide that a Medicare Chronic Disease Management Plan is required in addition to the Medicare annual health assessment.

If the GP decides to manage the person's complex health care with multi-disciplinary specialised health support, the GP can refer the person to:

- a specialist health professional who the GP liaises with directly
- a Specialised Intellectual Disability Health Service (SDS) who will coordinate treatment arrangements (see section 2.4.1)
- an allied health professional to manage particular chronic conditions such as, dysphagia or mental illness
- a pharmacist to review the person's medications under Medicare item 900, Domiciliary Medication Management Review (otherwise known as the Home Medicines Review).

If the GP or health professional decides that a Chronic Disease Management Plan is needed, make another appointment with the GP or health professional at the end of the consultation (see section 4.2).

☞ Refer to the Chronic Disease Guidelines for more information relating to the support worker's role in supporting a person with a chronic disease.

STEP 12: Obtain a copy of the health assessment

By the end of the consultation the GP should have outlined how the person's health needs will be coordinated and managed. It should be clear to the person and support worker what actions they need to take after the appointment.

The GP is required to provide a copy of the Medicare health assessment at the end of the appointment. Support workers may need to ask the GP to print out a copy for the person.

It is important to tell the GP that the information in the health assessment needs to be easy to read and understand, as it will be used by non-clinical staff to support the person to manage their health.

Before leaving the consultation, go through the health assessment with the GP to ensure that you understand what has been recorded and what recommendations have been prescribed. If there is any action that is not clear, you must seek clarification from the GP before the end of the consultation.

Any changes to the health assessment document must be made by the GP. At no stage should support workers transcribe or rewrite any written information provided by the GP in the health assessment document. This is the responsibility of the GP. This also relates to other health appointments the person attends during the course of the year.

In addition to the health assessment report, the person and support worker may need to prompt the GP to:

- prescribe new and ongoing medication prescriptions for the person
- prepare a referral to a Specialised Intellectual Disability Health Service where required (see section 2.4.1)
- prepare a referral to any other health professional such as a Public Oral Health Service or allied health professional
- provide written endorsement of reviewed and updated support plans. For example an epilepsy management plan, oral health plan, asthma management plan, allergy management plan, skin care plan, bowel management plan
- record changes to prescribed medication in the:
  - medication chart/ Webster-pak® Signing Sheet,
  - **My Medication Record** (refer to the Medication Procedures).

The person may have a reaction to new medication and it is important that the person and support worker ask the GP:

- what the person may experience as a result of a change in medication regime
- how long to monitor the person for sign of a reaction
- when to seek medical advice if a reaction does occur.

STEP 13: Actions after the appointment

Update the **Health Action Plan** to keep track of the completion of health actions prescribed by the GP.

If the Appointment Checklist tool was used to prepare for the health assessment, with the person work through Checklist 3 of the **Appointment Checklist**, ‘After the appointment’ and complete each of the actions listed in the Health Action Plan.

5 Oral health

This section relates to the Health and Wellbeing Policy Guiding Principles 6, 11, 12, 13, 14.

5.1 Annual dental review

Every person living in an ADHC operated or funded accommodation support service requires an **annual dental review**. It is best practice for the annual dental review to be completed around the time of the person's annual health assessment.

Dental health is one of the criteria listed in the Medicare health assessment item. During the health assessment appointment, the person's dental and oral health is reviewed by the GP. If the person does not have teeth, the GP assesses the condition of the person's gums and mouth at the time of the health assessment.

If the GP thinks it is needed, a referral is made to dental health services in the following circumstances:

1. The person has not previously accessed and is eligible for free Public Oral Health Services including the NSW Oral Health Fee For Service Scheme (OHFFSS)[19]
2. The person is not suited for routine dental care at a Public Oral Health Service and has not previously accessed and is eligible for Special Care Dentistry Services[20]
3. The GP has difficulty assessing the condition of the person's teeth and mouth. For instance the person may be reluctant to open his or her mouth at the time of the health assessment.

If the person is unable to consent to the referral, a person responsible is required to provide consent. If there is no person responsible or the person is objecting to treatment, seek advice from the NSW Civil and Administrative Tribunal (NCAT) (previously the Guardianship Tribunal)[21].

The person may choose to visit a private dentist instead of the free Public Oral Health Service. Accessing a private dentist will depend on the person's:

- physical abilities
- urgent need of dental care
- financial capacity or private health insurance with dental care extras.

Prior to a dental appointment, information about the person's communication and support needs may be provided to the dentist to facilitate the appointment.

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[19] OHFFSS

[20] Oral Health Specialist Referral Protocols PD2011_071

[21] NSW Civil and Administrative Tribunal (NCAT)

☞ Refer to Information on accessing free Public Oral Health Services including Specialist Dentistry is provided on the NSW Health website and the Health Planning Procedures, ‘Other resources’.

5.2 My Oral Health Plan

Each person living in an ADHC operated or funded accommodation support service (group home, Large Residential Centre and Specialist Supported Living) **must have a current oral health plan**. The oral health plan used in ADHC operated accommodation support services is the **My Oral Health Plan.**

There are four parts to the My Oral Health Plan. The first part records information on the support the person needs to maintain adequate oral health and hygiene. This information is recorded by the person and/or a support person who knows the person well.

My Oral Health Plan

The second and third parts of the My Oral Health Plan is a record of the prescribed oral health routine and the outcome of the oral health review recommended by the dentist or the person’s GP, including future actions. Changes to the person’s My Oral Health Plan are made by the GP during the health assessment if the person does not have teeth or by the person’s dentist at the person’s annual dental review.

The fourth part of the My Oral Health Plan provides evidence that the plan has been completed and endorsed by a health professional. The line manager (e.g. Team Leader) must also sign and date that they have reviewed the outcome and recommendations made by the health professional at the dental review.

Before leaving a dental appointment book the next dental review. Record the appointment date in the person’s My Oral Health Plan.

☞ Further information relating to oral health and hygiene is provided in the Nutrition and Swallowing Guidelines of the Health and Wellbeing Policy and Practice Manual, Volume 1 and the Chronic Disease Guidelines in the Health and Wellbeing Policy and Practice Manual, Volume 2.

6 Index of tools and templates

7 Policy and Practice Unit contact details

You can get advice and support about this Policy from the Policy and Practice Unit, Contemporary Residential Options Directorate.

Policy and Practice, Service Improvement

Contemporary Residential Options Directorate

ADHC

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