

Section 3: Direct service delivery and case management

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Overview and issues in this section

The delivery of direct services is a critical component of business for funded organisations. The provision of direct services means working with and for people in order to provide appropriate support solutions to meet their needs. This can include the provision of information or advocacy services, assessment, housing, financial resources, case managed support and crisis accommodation. Direct service delivery works to provide people with tailored housing and/or support solutions that aim to resolve housing difficulties or crisis and enhance people's opportunities for social participation. Service provision places an emphasis on creating a safe environment that enables people to make decisions and take more control over their lives.

Direct service delivery focuses strongly on engaging and supporting people within a case management or consumer support framework. Assistance can be provided in relevant areas, for example; advocacy, emotional support, parenting assistance, living skill development and family re-unification in conjunction with increasing people's access to secondary services such as income support, legal assistance, employment, education and training. Tailored support solutions may mean offering people the opportunity for referral or case coordinated responses with specialist services, such as family violence, drug and alcohol or mental health services.

Direct service can take place in a variety of settings including community outreach, office or accommodation-based settings, home visits, one-on-one activity or support, group work or informal opportunistic intervention.

This section is to be read in conjunction with 'Section 4: Direct service delivery to specific groups', which covers organisational practice for assisting parents and children, young people, people experiencing family/domestic violence, cultural competency and specialist advocacy services.

Documents that further support these standards include:

- National Supported Accommodation Assistance Program Case Management Principles (Commonwealth 1996)
- Quality Improvement in Case Management (Department of Human Services 1998)
- Working With A Multicultural Community (Department of Human Services 1998)
- Duty of Care (Department of Human Services 2000)
- Language Services Policy (Department of Human Services 2006)
- Homelessness Assistance Program Guidelines and Conditions of Funding (Department of Human Services 2006)
- Code of Practice for Specialist Family Violence Services for Women and Children (Domestic Violence Victoria 2006)
- The Protocol for the Case Management of Unsupported Young People (Commonwealth and States)

Standard 3.1: Providing equitable access to support services

People are provided with fair, equitable and transparent access to support.

People should not be disadvantaged in accessing services through discriminatory practices or poor service design.

The following features and examples are not meant to be exhaustive or prescriptive, but rather give some guidance to services in how to achieve this standard.

Documentation that can support good practice

Signposts of good practice

3.1.1

The organisation has policies and procedures that reflect a commitment to providing equitable support to the full range of people within their target group and fair ways of deciding whether to accept a referral for support.

Further explanation and examples

Commitment to equity in accepting people into support

Policies and procedures that guide acceptance for support on an equitable basis will show a clear commitment to non-discriminatory practices and demonstrate a willingness to work with a range of people. Policies also need to provide guidance for decisions about whether to accept a referral or request for support, which take into account the organisation's current capacity and the needs of people already accessing services. Having clear policies and procedures makes the equity and fairness of access to services transparent.

Organisations use an entry criterion that does not exclude people on discriminatory grounds. Organisations should base reasons for not accepting a referral on non-discriminatory and non-judgemental eligibility criteria that is fully documented and openly explained.

Processes that can support good practice

Signposts of good practice

3.1.2

The organisation's offices, venues and activities are accessible to its potential and current consumers.

Further explanation and examples

Accessible locations

Offices and venues may not be centrally located, but should always be well signposted (with the exception of some family violence services) and linked to road and public transport routes.

Where disabled or pram access to venues is not possible, the organisation might offer an out-posted service in a more accessible location to meet these needs (for example, a half day in another space, home visits or arrangements to meet people in a public area). Organisations may also consider partnership approaches to offer full or part time co-located services and sharing of resources. Casual room hire from another business or organisation could also be an option.

Offering a reverse charge telephone service or toll free number can also enhance service access. Information about the agency can be distributed to other community organisations, such as community health services, in order to promote access to the organisation.

3.1.3

The organisation has operating hours that meet the needs of the range of people seeking assistance and people know what to do if they have concerns after hours.

Suitable operating hours

Funded organisations should demonstrate a commitment to maximising the access people have to services, including a commitment to the delivery of a face-to-face response where possible. Feedback from people seeking assistance should identify if the current operating hours are creating barriers to service access. In instances where access barriers are identified, the organisation may need to develop flexible approaches to service design, based on organisational capacity.

At a minimum, the organisation should have an answering machine with a recorded message detailing business hours and contact names and telephone numbers for emergency or after-hours access. The recorded message should also offer information about how people can access local or state-wide services after-hours, including contact numbers for women escaping family violence, single people, couples or families needing emergency accommodation. Access will also be enhanced if the organisation provides people with telephone contact options i.e. a toll free number, accepting reverse charge calls or contact phone cards.

Crisis day support services and residential crisis accommodation services should ensure that people understand when and how to make contact with staff.

Services working with children and young people will need to consider when these people are available, and within agency capacity, roster staffing around school or work commitments and public holidays.

Making outreach services easily accessible

People seeking assistance should be able to easily contact outreach staff when they need to and should be told of the arrangements for contacting outreach or alternate support services after hours. Strategies to enable access can include promoting outreach contact numbers, choosing venues for meetings that are safe and convenient for the person seeking assistance and having a toll free number people can use when they need to make contact.

3.1.4

The organisation provides people with clear information about the organisation, the support it offers and any limitations of that support.

Information about the organisation and the services offered.

At the point of acceptance for a support service, organisations should provide people with information outlining:

- the organisation's values and ethical framework
- the organisation's decision making processes and complaints mechanisms
- the support the organisation provides and any fees
- how to best use the support offered and the processes the organisation uses
- any support limitations.

Signposts of good practice

Further explanation and examples

3.1.5

The organisation monitors the outcomes of referrals and requests for support it receives to ensure it is providing equitable and accessible services.

Monitoring referrals and requests

Organisations should monitor referrals received, both at an individual level to measure personal outcomes against the individual's expectations and needs, and more broadly to understand service delivery patterns. The organisation should also implement, monitor and review the effectiveness of guidelines for the provision of appropriate and timely feedback to referring agencies.

Standard 3.2: Engagement, assessment and case planning

Each consumer has the opportunity to actively participate in an assessment and planning process that is strengths-based and emphasises long term solutions.

Consumers are central to discussions about identifying and meeting their needs.

The following features and examples are not meant to be exhaustive or prescriptive, but rather give some guidance to services in how to achieve this standard.

Documentation that can support good practice

Signposts of good practice

3.2.1

The organisation has a documented system for case planning which reflects a commitment to flexible and consumer-centred approaches.

3.2.2

The organisation's documented system for case planning includes ongoing assessment and uses an assessment tool that encourages people to consider their needs within a holistic framework.

Further explanation and examples

Case management framework

The Supported Accommodation Assistance Program Case Management Principles provide a minimum framework for all services to develop case planning processes. In addition, the Code of Practice for Specialist Family Violence Services for Women and Children provides a model for best practice for services that provide responses to women and children experiencing family violence.

Organisational policies and procedures should include a commitment to consistent, transparent and accountable practice that incorporates guidance on:

- consumer participation
- flexibility of responses
- time management and boundaries/responsibilities
- case load management
- consumer and staff safety and risk management
- integrated or specialist partnership responses
- case planning and review
- staff ethical code of conduct.

Documented assessment system

The organisation should fully document the assessment process, including tools utilised, in staff guidelines and training manuals.

Assessment tools

Organisations should utilise common tools and practice guidelines developed for housing support, homelessness or family violence risk assessment. These tools will assist the practitioner to develop an understanding of the person's immediate situation, after which a broader assessment and planning approach can be explored within the context of case planning. Assessment and planning processes support people to explore immediate and longer-term issues. Assessment is an ongoing process, driven by the individual and guided or supported by the case manager. Assessment and planning approaches should be goal orientated and constantly evaluated.

The case manager should assist the individual to explore identified issues i.e. social, cultural or emotional needs, children's requirements, health, housing, personal safety, income support, education or training etc. At the same time, the process will need to be sensitive to the person's ability and willingness to reveal important aspects of their life.

3.2.3

The organisation's planning documentation clearly identifies how case coordination occurs both internally between programs and externally with other providers.

3.2.4

The organisation guides the delivery of direct services to all people by providing staff with written information on relevant legislation, regulations, policies and procedures.

Coordinating case support

The organisation's documentation will detail how coordination of case management practices occur within a transparent and integrated framework that supports best practice. Documents could include:

- Memoranda of Understanding between agencies
- internal program protocols
- shared tools, including assessment and referral mechanisms
- agreed processes for accessing specialist advice or assistance
- guidelines for joint case management or case conferencing
- guidelines for managing caseloads, grievance processes and critical incidents.

Documentation to guide working with people

Some examples of relevant legislation or processes are:

- the United Nations' Principles on the Protection of People with a Mental Illness and Improvement in Mental Health Care
- Code of Practice for Specialist Family Violence Services for Women and Children 2006
- Victoria Police, Code of Practice for the Investigation of Family Violence 2005
- relevant mental health legislation
- drug and alcohol harm minimisation policies and practices
- Information Privacy Act 2002 and Health Records Act 2001
- The Children, Youth and Families Act 2005
- Duty of Care, Department of Human Services 2000
- Residential Tenancies Act 1997
- Victorian Civil and Administrative Tribunal
- Office of Housing Policies and Procedures Manuals.

Signposts of good practice

3.2.5

Skilled and knowledgeable staff conducts consumer assessments.

3.2.6

Staff use a range of strategies in order to build rapport and trust with people.

Further explanation and examples

Assessing people

Organisations should ensure that staff have appropriate knowledge, experience and skills to conduct consumer assessments as well as appropriate supervision, mentoring and support. Staff participation in training and personal development opportunities should be encouraged. Organisations should foster cross program and sector networking activities that further enhance personal development and linkage opportunities for staff. Staff should seek the assistance of or consult with specialist agencies, i.e. family violence services, mental health or drug and alcohol services where further guidance or assistance is required to maximise outcomes for people seeking a service.

Promoting engagement

Some specific practices staff might use include:

- building on strengths to enhance self-esteem and confidence rather than focusing only on the person's problems
- dealing with resistance by working on small tasks and achieving incremental change
- using coaching strategies and working alongside the person as a mentor
- joining with the person in seeking to understand the impact of their past or current behaviours
- working through individual issues with perseverance
- persistence and patience during times of crisis, emotional turmoil and risk taking
- being consistent and clear about service responses and limitations.

3.2.7

Each person is supported to actively participate in the case planning process.

Joint case planned support

The case planning process should be client driven. Indicators of good practice include:

- each person is encouraged to participate in the planning process, at a mutually agreed place and time
- each person is encouraged and supported to identify their needs, strengths and resources
- each person is supported to identify their goals, priorities and timeframes
- each person is provided with opportunities to explore and clarify issues with regard to his/her situation.

While the organisation will address a person's crisis or short term needs first, case managed support should also have a strong focus on assisting people to meet longer-term outcomes. Longer-term solutions will mean planning for sustainable affordable housing, rather than just crisis or transitional accommodation. Longer-term solutions mean building in a range of services or resources that assist the individual or family in other life areas such as personal relationships, legal, health or income support or education, training and employment opportunities.

The planning process should detail what the person is responsible for doing, what the service will do and what any other parties will do. The organisation needs to check with the person that all information is correct and all actions are agreed to. Case planning should be done from within a strengths-based framework that acknowledges and builds on the person's successes and capacities.

People with high or complex needs may require the support of a friend, family member, advocacy service or carer to assist in advocating on their behalf during the case management process. People who have multiple or complex needs often require a range of specialist service responses. For this reason, the building of strategic partnerships with specialist providers is critical to gaining and sustaining short and longer-term outcomes for people. Some of these services may include mental or community health, general medical practitioners, private psychiatrists, rehabilitation or disability support services and religious or spiritual leaders.

3.2.8

People have access to a copy of their support plan.

People's access to their support plan

Privacy legislation makes this a legal requirement of service providers.

Good practice includes offering people a copy of their plan and advising people how to access personal information held by the organisation.

3.2.9

Coordination of services with other agencies is explored and negotiated in development of case plans.

Developing a coordinated service

With consumer consent, service co-ordination may involve:

- initiating relevant referrals in accordance with agreed case plan
- working with the consumer and professionals to ensure that enough, but not too many, services are engaged at one time
- ensuring role clarification of all parties with the consumer and other professionals
- agreement in regard to what information can be shared
- agreement on who takes a lead, co-ordination or case management role if this is required
- negotiation and agreement with regard to case handover, exit planning or case closure.

3.2.10

The organisation provides people with written information about other services that might assist them.

Written information about support services

Organisations may choose to develop personal information packs or wallet size resource cards for consumers.

Information packs or cards should include information about the services offered by the funded organisation in addition to contact details for other local and Statewide services. Alternatively, organisations may provide up to date pamphlets and information on behalf of other relevant services.

Measuring outcomes to support good practice

Signposts of good practice

3.2.11

The organisation regularly reviews its assessment and case planning processes to ensure they are consumer-focused and address immediate and longer term needs.

Further explanation and examples

Reviewing assessment and case planning

Reviews could include case file audits which monitor the assessment and case planning process to ensure:

- flexible, responsive and holistic service responses
- application of mutually agreed plans, including the provision of assistance to support applications or referrals for other services
- application and appropriateness of financial resources
- appropriateness of referrals
- effectiveness of case co-ordination when multiple services are provided at any one time
- consumer outcomes and exit plans against case plan goals
- adequacy of file records

Review processes can also monitor:

- staff supervision and support
- pre and post exit consumer feedback
- the frequency of people returning to the service
- feedback from other agencies.

Standard 3.3: Responsive support

Each person receives appropriate support to achieve the goals of the case plan they have negotiated with the service.

Skilled and appropriate assistance from service providers can make it possible for people to achieve their goals and have better lives.

The following features and examples are not meant to be exhaustive or prescriptive, but rather give some guidance to services in how to achieve this standard.

Documentation that can support good practice

Signposts of good practice

3.3.1

The organisation has a documented system that ensures people gain flexible support to meet their needs.

3.3.2

The organisation's documentation reflects a strong commitment to meeting the needs of each person, through the least intrusive support solutions.

3.3.3

The organisation has documented systems to ensure an ethical framework guides service delivery.

Further explanation and examples

Providing flexible support

Within funding guidelines, the service needs to be responsive to the diverse range of people's needs, rather than merely trying to fit people into the service model. A documented system may include policies and procedures for case planning and review, referral protocols and agreements with other organisations to provide additional services, guidelines for using brokerage funds or other discretionary resources, and policies and procedures reflecting a commitment to a consumer focus.

Least intrusive support

The documentation should acknowledge the rights of all people seeking assistance, including the right of each person to choose the least intrusive solutions and indicate these rights will be upheld, regardless of the complexity of behaviours.

Advocacy

The organisation's policies should provide staff with guidance on how and when to advocate for individuals in addition to articulating the organisation's approach to advocating on housing, family violence or homelessness issues within the community.

Ethical practice

The organisation should promote and provide services within the boundaries of an ethical framework which may be documented through:

- a statement of organisational values
- staff code of ethics (covering issues related to honesty, respectful treatment, non-discriminatory or harassing behaviors', boundary setting, conflict of interest and confidentiality)
- policy and procedures outlining duty of care obligations.

3.3.4

Group work programs offered as part of service delivery are well documented.

Documentation of group work

Accountability frameworks for the provision of group work activities should require documentation of:

- program plan/s
- facilitators profile & qualifications
- learning outcomes
- risk management process
- personal information, including consent forms
- promotional or resource materials
- catering requirements
- transport and venue arrangements
- additional staff requirements
- consumer input and evaluation methods or processes
- budgets.

Processes that can support good practice

Signposts of good practice

3.3.5

The organisation encourages people to drive decision making within their case plan.

Further explanation and examples

Involving people in decision making

Some people may initially feel overwhelmed or be reluctant to engage in setting directions for their case plan. It is important for staff to take time to build a rapport with people. On going mentoring, information, support and encouragement will assist people make informed and empowered decisions about their lives.

3.3.6

The organisation gives people clear explanations about what services can be provided, service limitations, and the other resources available to them in the community.

Informing people about other services

Organisational staff should be aware of a broad range of community services and businesses that could assist people to make appropriate social and community connections. This can include, for example, youth drama groups, parents' groups, sporting clubs and other areas potentially of interest.

3.3.7

The organisation provides practical assistance and support within the agreed time frame or communicates any changes in arrangements in a timely manner.

Providing practical support

The organisation demonstrates a commitment to the delivery of responsive consumer services in a manner that is negotiated and mutual agreed to. Organisational procedures and case management audits clearly demonstrate the delivery of timely, reliable and punctual services, with any change to service arrangements clearly communicated to consumers and recorded as appropriate.

Practical assistance and support may include assisting people to *maintain* or *access* safe, sustainable housing and/or, other related needs, including:

- achieving a healthy lifestyle (by referral to health services, assisting with personal hygiene, food and nutrition, or helping in finding recreational opportunities)
- emotional support, parenting or relationship development, life skills and cultural or religious needs
- obtaining income support, legal advice, education, training and employment
- obtaining appropriate long term accommodations (by assisting with Segmented Waiting List applications, helping the person to negotiate in the private rental market, to re-locate or to re-establish)
- debt repayment agreements with utility or housing providers (by helping the person negotiate these agreements).

The service may directly provide the support required or share case management responsibilities with another agency.

3.3.8

The service the organisation provides is flexible and can adapt to the person's changing circumstances and capacity.

Providing flexible support

The goal in casework is to promote consumer independence by maximising access to resources and personal development opportunities. The level of support each person requires is likely to change over time. If a person shows little or no progress, a case review should assess the appropriateness of goals and interventions, the willingness of the person to engage and the strength of the relationship between the person and case manager.

Different intervention approaches may include an agreed change to case plan goals or tasks, providing agency staff with mentoring support or ideas, involving a consumer mentor or advocate, seeking specialist advice, incorporating group work as well as individual activities or allocating a new case manager as appropriate.

3.3.9

Staff understand and give appropriate consideration to duty of care issues in all aspects of service delivery.

Duty of care

Duty of care issues include:

- developing strategies to assess and prevent the escalation of risk or harm to people, including people residing in crisis accommodation
- supporting and taking appropriate action (including referral where appropriate) for people who have experienced abuse or expressed self-harming behaviours
- understanding legal responsibilities to people in critical situations
- understanding and demonstrating ethical boundaries of relationships between staff and consumers
- creating safe environments for people accessing services, with a positive service culture
- providing opportunities for people accessing services to resolve conflicts constructively, to improve communication skills and to develop positive personal relationships
- taking responsibility to intervene at any time during the case management process to reduce risk to consumers or staff
- implementing harm and risk minimisation strategies for service delivery, particularly when working with people experiencing family violence or people who are exhibiting challenging behaviours.

3.3.10

All staff have regular opportunities to meet with each other in order to exchange information relevant to the provision of good service delivery.

Staff opportunities to share information

All staff (particularly smaller or more isolated services) should have regular opportunities to exchange information with other staff or team members. Regular information exchange ensures coordination of services and examination of practice issues. Information exchange could occur through:

- staff or team meetings
- individual staff supervision sessions
- team conferencing around specific consumer issues
- shared case management meetings.

Signposts of good practice

3.3.11

The organisation monitors the quality and outcomes of its service delivery practices.

Further explanation and examples

Monitoring service delivery practice

The monitoring system could include reviews of:

Case planning and practice: (as per 3.2.1)

- quality and appropriateness of case plans
- measurement of goals or outcomes
- management of critical incidents.

Use of resources:

- use of Housing Establishment Funds or other specific funds.

Consumer feedback:

- consumers level of satisfaction (surveys and feedback)
- consumer complaints or grievances (numbers, themes, outcomes).

Staff support and human resource management practice:

- staff training needs analyses
- staff feedback through supervision
- distribution of staff case loads and ratio of complex or high needs support episodes.

Stakeholder surveys:

- particularly where the organisation shares case management or intake and assessment responsibilities.

3.3.12

The organisation evaluates its group work to improve the way it is designed and delivered.

Evaluating group work

Both participants and staff need to be involved in evaluating group work activities. Evaluation should consider both process and outcomes for participants.

3.3.13

The organisation monitors and reviews its case coordination processes to ensure they are efficient and effective.

Monitoring

Information the organisation collects and considers could include:

- as per 3.3.11
- comparisons of time taken to complete planned tasks against planned timeframes
- feedback from other providers.

Cross references:

- Supporting parents and accompanying children (Standard 4.1)
- Supporting young people (Standard 4.2)
- Supporting women, children and other people experiencing family/domestic violence (Standard 4.3)
- Providing culturally competent services (4.4)

Standard 3.4: Exit planning and case closure

Each person is supported in developing a plan for exiting the service.

People will be able to maintain improved circumstances if they can plan for the ending of service use and receive support when they exit a service.

The following features and examples are not meant to be exhaustive or prescriptive, but rather give some guidance to services in how to achieve this standard.

Documentation that can support good practice

Signposts of good practice

3.4.1

The organisation has a documented process for exit planning and case closure that involves the people concerned and is integrated with other case management processes.

Further explanation and examples

Exit planning and case closure

Organisations should demonstrate that people are fully informed about the case management process, including exit planning or case closure. Clear and collaborative planning processes enable people to make informed decisions about their level of engagement with the service and minimises the likelihood of poor or unsustainable outcomes.

Policies, procedures or guidelines should cover:

- voluntary closure by the consumer
- involuntary closure (termination of service by the agency)
- collaborative planning for case closure between the person and the service.

Involuntary service termination should be avoided wherever possible. Staff should explore and implement alternative harm minimisation interventions in instances where it has been identified the individual is at risk to themselves or to other people. The organisation may review staffing requirements, seek to involve a specialist service or provide on going support from a more appropriate setting.

Processes that can support good practice

Signposts of good practice

3.4.2

The organisation gives each person whose support it terminates, a clear explanation and information on the circumstances in which it will reinstate support.

Further explanation and examples

Terminating support

Where the organisation has decided to terminate the service, the person should receive a clear explanation of why the service has been withdrawn, including an explanation of how their behaviour breached their responsibilities under the Consumer Charter or other service guidelines. Information should also be provided about how they may regain a service at a later time.

3.4.3

Each person is given the opportunity to review achievements, with a focus on maintaining them in the future, and to identify future goals and action plans.

3.4.4

Staff actively encourage and support people to achieve greater independence and social connectedness to their community.

3.4.5

People with high level or complex needs have appropriate ongoing support arranged before they exit the service.

3.4.6

People are informed about the steps necessary to re-access the organisation or other relevant housing, family violence or homelessness services.

Reviewing and maintaining achievements

Regular case plan reviews with consumers should include a review of achievements, adjustment of goals and/or action plans and a focus on how to maintain success and progress. Exit planning should also focus on these areas. In addition, organisations could undertake a post-service needs assessment and jointly develop strategies to enhance the sustainability of positive outcomes, such as stable accommodation.

Support during transition

An appropriate supportive community is one which provides the best possible opportunities for the household to live independently, including consideration of social, cultural and emotional supports, employment, safety and security, education, recreation, community and health services, transport networks etc.

For some people, the first step towards independence can occur through implementing activities that build self-esteem and confidence. Greater independence and social inclusion can result from offering people access to services or activities like:

- life skills training (cooking, shopping, cleaning, budgeting, paying bills)
- vocational training (short courses, volunteer work)
- health or personal development (dentistry or optical services, fitness/gym)
- recreational opportunities (sport, music, organised trips, community gardens etc).

Ongoing support arrangements

People with complex needs can be vulnerable and may require ongoing support from other community or specialist services. In these instances, the case manager should discuss the process for referral and case handover with the individual as part of the negotiated service exit plan. Good practice includes planning for a face-to-face introduction to the new service and file note transfer prior to service exit or handover.

People's future access to the system

Part of service exit planning will include providing people with information about how they can re-access the organisation or other services as appropriate.

Signposts of good practice

Further explanation and examples

3.4.7

The organisation monitors and reviews its exit planning and case closure processes to ensure people are actively involved and appropriately supported.

Reviewing exit planning

Effective monitoring of exit planning and case closure enables the organisation to assess the appropriateness of services provided during the support episode, and the sustainability of longer-term outcomes for people after service exit. Monitoring can occur through voluntary use of consumer pre or post exit surveys, use of goal obtainment measurement tools and by offering individuals short term negotiated follow up contact after case closure. Post exit contact provides people with additional security in the move to independence whilst allowing short term monitoring in case additional interventions or support are required.

Cross reference:

- Effective referrals (Standard 2.3)

Standard 3.5: Documenting case work

All key information about individuals and each stage of service delivery are documented.

It is more likely that plans will be carried through and appropriately coordinated if they are written down and agreed to.

The following features and examples are not meant to be exhaustive or prescriptive, but rather give some guidance to services in how to achieve this standard.

Documentation that can support good practice

Signposts of good practice

3.5.1
The organisation has a documented system for recording and managing case files.

3.5.2
Personal files contain appropriate and adequate information to assist good case management.

Further explanation and examples

Case file system

The documentation should cover:

- purpose of case files
- the information to be included in case notes
- how files are organised for ease of access to information
- case management forms or tools utilised
- use of unique identifiers (if appropriate)
- processes for electronic transfer of files or information
- Standard format for recording information in case plans
- how correspondence is to be handled
- how information is to be recorded or altered (for example, legible, objective, signed, dated)
- client access to files
- file storage and retrieval processes
- file auditing
- how long files will remain open
- procedures for closure, archiving and disposal of files.

Refer to Standard 1.4 for privacy implications.

Case file content

Case files may include:

- relevant personal information*
- screening or intake assessment
- case planning assessment
- support plans, goals and timelines for achievement
- risk assessment/s
- incoming and outgoing applications or correspondence (where applicable)
- referral records
- emergency and ordinary contact information
- consent forms (for sharing information)
- exit plans
- records of grievances (where applicable)
- tenancy agreements with a housing provider (where they exist)
- support agreements (where they exist)
- data collection forms (as appropriate).

*Only collect health or personal information that is necessary to deliver the service.

Processes that can support good practice

Signposts of good practice

3.5.3

All case plan entries are accurately documented, signed and dated in a timely manner.

3.5.4

Information recorded about people is written objectively and respectfully.

3.5.5

Staff record notes on the case file about critical incidents as soon as practicable to enable debriefing and accountability and to meet any external needs.

Further explanation and examples

Recording information in case files

In compliance with legislation, the organisation should take reasonable steps to ensure that health or personal information is accurate, complete, up to date and relevant to the provision of service.

Objective recording

File notes should be recorded in a manner that is respectful and does not include speculation or unsubstantiated opinion. Notes should clearly differentiate between staff observations and direct conversations.

Critical incident recording

Staff should accurately record observations, injuries and conversations as soon as practical following a critical incident. The recording of accurate information will assist critical incident debriefing or investigations by police, the Coroner, WorkCover, or other legislative bodies. *

*Organisations should demonstrate policies and procedures adhere to the Department of Human Services criteria for reporting and recording of incidents.

Measuring outcomes to support good practice

Signposts of good practice

3.5.6

The organisation regularly audits its client file system to ensure consistency in approach and quality of what is recorded.

Further explanation and examples

Auditing case files

The organisation should conduct regular case file and intake audits against funded programs. The audit process should be fully documented and any inconsistency in records should be recorded and addressed with staff. Organisations should use file audit results to review and improve practice by linking them to staff supervision and training.

Cross references:

- Rights-based approach (Standard 1.1)
- Privacy and confidentiality (Standard 1.4)