PAG pathways

a guide to implementing an active service approach to planned activity groups

Version 2. 2014
This project has been a joint initiative between:

Yarra Ranges Council

Caladenia Dementia Care

EACH Social and Community Health

Golden Wattle

Department of Health

Home and Community Care

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Acknowledgements

Thank you to all the staff, volunteers and people attending the PAG programs for their contribution and commitment. Without their participation and assistance, this project and guide would not have been possible.

Thank you also to Shannon Reddaway for taking the photos used in this manual.

Welcome

Welcome to Version 2 of the PAG Pathways manual.

As the implementation of the ASM has moved forward in the last 3 years, many Planned Activity Groups are now further along the track of active and participatory service provision. Many staff have also received formal training - but this guide is still a valuable resource for new staff, and for experienced staff to gain inspiration and reminders.

We hope you find Version 2 as useful as the first.

Many staff and volunteers are already practising various principles of the ASM.

This guide is designed to be a companion and reference for all staff and volunteers supporting people (and if applicable their carers) who attend a PAG.

You are encouraged to read this resource and use relevant parts in your team meetings, volunteer meetings, and we suggest making ASM a regular item on your team meeting agenda.

Please share this resource guide with others who may find it useful.

If you have any questions, please do not hesitate to discuss your question with your Supervisor.

The reference group generously shared their skills, experience, passion and time and without their assistance, this project would not have been possible.

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Aim of our Planned Activity Groups

Planned activity groups (PAG) are designed to enhance people’s independence by promoting physical activity, cognitive stimulation, good nutrition, emotional wellbeing and social inclusion. For people with carers, planned activity groups (PAG) are also designed to support care relationships. Planned activity groups may be targeted broadly to the The PAG programs HACC target group or to particular subgroups such as people with dementia, carers Home and Community Care (HACC) only, or carers together with the person they care for.

This is done by providing meaningful social and recreational activities in a supported and non-threatening group environment. The individual programs address the physical, social, cultural, emotional and recreational needs of the people who attend, and provide opportunities for social interaction and support. The programs are designed around choice and ability of the people attending, and emphasis is on enjoyment and fun, improving self-esteem through independence, both socially and maintaining or improving physical or cognitive capacity.

The groups provide a planned and reliable service for people attending, focussing on maintaining peoples’ ability to live at home and being involved in the community. Careful program planning and implementation ensure that individual needs are catered for, within the wider group programming and the activities focus on enhancing and/or maintaining the skills people require for daily living. There is a focus on being aware of the abilities and strengths of the members and what they have to offer, rather than what they are unable to do. The PAG staff welcome and actively seek input and provide regular opportunities through surveys and forums etc. For suggestions from people attending the groups (and carers) for activities and outings for the Group.

Activities are held both “in-house” at the PAG venue and within the community. For example, shopping outings, 10 Pin Bowling, concerts, movies, day trips and holidays.

PAGs also provide support and respite for the carers of people attending the groups.

For further information, please refer to the Planned Activity Groups Section of the Victorian Home and Community Care Program Manual 2013.
What role does PAG play in Active Ageing?

- Provides an opportunity for social connections for people who are often isolated
- Encouragement and support for people to actively participate as much as possible
- Friendship
- A place of belonging
- Respect and dignity to all
- Non threatening and safe
- Meaningful activities and enjoyable outings
- Can improve quality of life
- People are seen as individuals and the program is person centred
- No sense of hierarchy – everyone in the PAG is important
- Having a voice / opportunity for feedback and suggestions that will be heard
- Activities and outings that are designed or modified to suit the needs, abilities and desires of group members
- A link into your local community and possibly an opportunity to link into other services whilst attending the PAG (particularly if geographically isolated)
- Maintaining or improving skills and abilities of people attending
- Opportunities to learn from guest speakers for example:
  - Occupational therapists regarding suggestions on making a home safer (ramps, internal and external grab rails & handles, personal alarms etc)
  - Services available from local council and service providers to assist a person to stay in their own home for as long as possible and practical
  - Local Police or Neighbourhood Watch regarding home safety
  - Health promotion (Men’s health, quit smoking, stroke awareness, weight management etc.)
- Quality respite for carers
- Support for carers – individually and in groups
- Enjoyable and fun

The Home and Community Care (HACC) program is designed to support people whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long-term residential care. Eligibility does not depend on age or income. The Home and Community Care (HACC) providers use priority of access guidelines to manage demand for services.

PAG Target Groups

**Primarily**
People who are eligible to receive Home and Community Care (HACC) services are:

- People living independently at home, even with the support of carers but still living at home (not living in residential settings - hostels, nursing homes, facility based accommodation etc.)
- Frail, older people
- People with a physical, functional, sensory, intellectual or psychiatric disability
- People with dementia
- People with an acquired brain injury, and carers and their families to assist them in their role by providing respite, information and support.

Within the HACC target group, special needs groups have priority of access to HACC services according to their assessed individual needs:

- People from culturally and linguistically diverse backgrounds;
- Indigenous people;
- People with dementia or other related disorders;
- People who are financially disadvantaged;
- People who are frail aged and other people with disabilities living in remote or isolated areas; and
- People with multiple disabilities and complex support needs.

Diversity planning and practice aims to improve access to services for eligible people who are marginalised or disadvantaged, and to improve the capacity of the service system to respond appropriately to their needs.

Reference: Victorian Home and Community Care Program Manual 2013
Activity Planning:

This extract is from the 2003 edition of the HACC Program manual, and it explains clearly the importance of activity planning. (please note this edition has been replaced by the 2013 HACC Program Manual)

The activity plan should be sufficiently structured in content and process to ensure that there is adequate opportunity for consumers to meet and relate to each other in a personal and friendly atmosphere.

Planned activity programs should be regularly assessed and reviewed in relation to their suitability, effectiveness and outcomes, including cultural and age appropriateness and relevance to consumer’s assessments and care plans.

When planning activities the preferences of consumers should be sought. Consumers should have an opportunity, at least once per month, to discuss future activities, including group and individual preferences and cultural and age appropriateness of activities.

Please also see page 154 of the HACC Program Manual 2013, for more information on activity planning.

When planning activities it is useful to consider the following questions:

- Does the plan take notice of feedback from staff, volunteers, consumers and carers about past activities and preferences expressed for new activities?
- Is the plan responding to information about individual consumer needs gathered during the assessment?
- Does it create opportunities for companionship and friendship?
- Are activities designed to enhance daily living skills?
- Are the activities appropriate for the age of the consumers? For example with older people use past life experiences in an oral history project
- Does it include and encourage appropriate levels of physical exercise and activities?
- Is there a balance between social, intellectual and physical stimulation and between large group, smaller group and individual activities?
- Have some different ideas for activities been sought from relevant publications and from other PAG providers?
- Does it provide opportunities for celebration of culturally relevant festive days, holidays or other celebrations such as birthdays and anniversaries?
- Can the group participate in local community activities, such as street festivals, art exhibitions, library activities, concerts etc?
- Are people having fun and at the same time, participating in activities that will maintain skills, such as hand / eye coordination?

You will find more information in the “Service Delivery Section”
There is a world wide movement towards the principles of ‘active ageing’.

What is ‘active ageing’?

Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. It applies to both individuals and population groups.

Active ageing allows people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society, while providing them with adequate protection, security and care when they need.

The word “active” refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. Older people who retire from work, ill or live with disabilities can remain active contributors to their families, peers, communities and nations. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age.

“Health” refers to physical, mental and social well being as expressed in the World Health Organisation definition of health. Maintaining autonomy and independence for the older people is a key goal in the policy framework for active ageing.

Ageing takes place within the context of friends, work associates, neighbours and family members. This is why interdependence as well as intergenerational solidarity are important tenets of active ageing.

4  http://www.who.int/ageing/active_ageing/en/index.html
What is the Active Service Model?

The ASM approach is supported by five key principles:

1. **People wish to remain autonomous**
   - People have the potential to improve their capacity
   - People’s needs should be viewed in an holistic way
   - HACC services should be organised around the person and his or her carer
   - A person’s needs are best met where there are strong partnerships and collaborative relationships between the person; their carers and family; support workers and service providers

How these principles relate to your PAG service:

“Working with the person to stay as active, connected and independent as possible”

1. **People want to remain autonomous**
   - This means respecting a person’s self determination, choices and decision making, that people want to maintain (or regain) their independence, to be informed and make decisions and choices on things that effect their life. The ASM aims to assist a person to feel supported in making their own choices and that they have control and a say in what happens in their life.

   As staff or volunteers working in a PAG, this model of service means being aware of providing support and encouragement for people to do things for themselves, and even to encourage people to assist each other if they are able. This is reinforcing the shift from “doing for” people, which can create and encourage dependency to “doing with” which encourages activity and being more involved. People attending the program may notice a change and comment (in jest of course) that “you’re not doing your job” – you can introduce the changes slowly and it may take a little while for some to get used to doing more for themselves – but you ARE doing your job and in time they will probably accept the changes as a normal part of the program.

   Other examples include:
   - managing as many of their own day to day activities as possible
   - choice and supports to live independently for as long as possible
   - being involved and in control of decisions which effect their life – health issues, financial, holidays, housing etc..
   - Contributing to the desired outcomes of their “social profile / goal plan” etc..

2. **People have potential to improve capacity**
   - This means approaching all HACC service users as having capacity to improve their function and wellbeing, if only in small ways. An example of this is when a person wants to walk their dog daily, independently. In this instance, the worker could suggest working with an Occupational Therapist to put together a care plan outlining the steps required to meet this goal – this could include participation in a falls prevention group, strength building exercises, rails on the external stairs etc.. By finding a way to continue walking the dog, the additional benefits for the person could include feeling better for being outdoors, vitamin D intake, exercising, meeting people on the walk, improved self esteem and confidence etc..

   For many PAG workers this is another way of supporting people – as workers we all want to help but often “doing with” and not “doing for” can be far more empowering for the person. People attending the group can be encouraged and supported to do things for themselves – e.g. getting their own drinks, meals, making suggestions for activities and outings that the group could do, (if appropriate) transferring in and out of the car / bus, assisting others where able and needed, sharing the roles in the activity group and even encouragement to talk to another person attending the group. By encouraging people to talk, there is the possibility of a friendship being formed. Even if people are not “big talkers” – they may not be confident due to a stroke, may be naturally quieter, English may be their second language, the value of sitting and listening, and being a friend and companion cannot be underestimated.
3. People’s needs should be viewed in an holistic way

As we know, independence is broader than physical functioning. This is about working with people in a way that sees them as a whole person with a history, a life and many years of experiences and then focussing on what is meaningful and important to them. It’s a ‘person-centred’ approach, which promotes wellness and active participation and encourages the person to be involved in decisions that affect their life. It is accepting that individuals will have different motivations and goals and understanding these to best support the person. There is a need to look beyond the suite of services that HACC or particular agency provides and try and find the best solutions for the person. Looking at the “whole” person, not just seeing what they can’t do but what they can do.

Ask, Listen and Observe.

Instead of treating an illness or responding to a physical restriction, holistic care looks at an individual’s over-all physical, mental, spiritual, and emotional well-being. What are (and were) their interests, provide an opportunity for the person to tell their story – and for it to be heard. What is their country of birth, did they immigrate, cultural background and interests, their career, travel, family/children etc. Be aware of their personal situation – what is important to them, what is their story? For example:

Do they care for someone else:
partner, dependent adult child, neighbour, family member, the level of care required, how are they coping, are there other services that could assist them etc...

Do they live alone:
do they have someone (family / friend) to assist them if required, do they have the companionship of a pet, are they able to get to the shops for food, medical appointments etc., what does living independently mean to them / why is it important to them, are there other services that could assist the person etc..

Do they have a carer:
What things do they like to do at home for themselves, what would they like to do more of etc.

4. Services organised around the person

Traditionally – an agency has provided a range of services – and then fitted the person into the service. With this approach, it is thinking about the person first and agencies putting the person first. For example, when a new person is commencing the PAG, in full consultation, finding the day, activity level and dynamics that best meets the needs and interests of the person, and not just offering the person the group that is most convenient for the staff and program. A shift from when the PAG offered a program and people had to fit in and accept what was on offer. PAG programs must now actively ask for suggestions from the people who use the program and this is done through conducting regular surveys and community forums which are open to the PAG attendees, carers and volunteers. This gives people the opportunity to express ideas and thoughts and if possible, these suggestions will be explored and incorporated into the monthly plan (as a “one off” or a regular activity).

Suggestions are also gained through informal general discussion during the group, meals etc. and staff will ensure they record the ideas for future planning days.

For example, can activities, an outing or a guest speaker etc be arranged that would support or be relevant to people’s interests. E.g. through discussion (and from the Social Profile / Care Plan as demonstrated in chapter 4) a person attending the group shared with the group that he was a decorated RAAF pilot in the Second World War, he then went on to be a career pilot with Ansett before retiring. Perhaps suggest to the group that a visit to the RAAF Museum would be of interest, and our Pilot could be the guide for the day.

5. Collaborative working relationships

A person’s needs are best supported and met when there are strong partnerships and collaborative working relationships between the person, their carers and family, support workers and between service providers. The information shared is treated with respect and dignity, working towards the best outcome for the person. By forming collaborative partnerships, the person is able to receive the most appropriate level of support and should avoid under or over servicing. They should receive better care, integrated care, have more people to call on and have the right range of services. Partnerships also build trust and improve awareness of each other’s work.

For example, during a general discussion at the PAG, a gentleman who lives alone reveals this is one of the few outings he has in the week, the volunteer driver comes to the front door, collects him and assists into the bus. He is not able to easily and safely leave his home due to rotting, slippery external steps and railings. When asked, he admits he’s had two (2) recent falls. During further discussion, the PAG worker asks him about rails around the house, including the shower etc and how he’s managing his meals, grocery shopping etc and if he’s losing confidence in leaving the house. He says he doesn’t have any railings in the shower or on internal/ external stairs. He also said he waits for a neighbour to take him shopping but it’s an informal arrangement and sometimes there’s not much fresh food left in the house.

The PAG Lead program worker has a chat with him and with his consent, gives the person the relevant phone numbers for Local Council for Living at Home Assessment and Local Community Health Centre, for OT Assessment. If the person or their carer is not capable for making those enquiries, the PAG Co-ordinator may gain permission to make the referral themselves.

There is a focus on ‘wellness’ or ‘active ageing’ within an ASM approach:
• promoting a ‘wellness’ or ‘active ageing’ (refer to information in chapter 2) approach that emphasises optimal physical and mental health of older people and acknowledges the importance of social connections
• holistic and family-centred approach to care
• actively involving people receiving services in setting their goals and making decisions about their care
• providing timely and flexible services that support people to reach their goals

This will assist in maximising independence and it believed that people are best supported when services are tailored and are delivered to suit the person’s needs.

Why was the ASM introduced?

This initiative has been introduced by the Department of Health – HACC in Victoria, it is also a quality improvement that is being implemented into health and community settings across Australia and also internationally.

Due to an ageing population, HACC expects an increase in demand for the services they provide and know there will be a need to manage this effectively, fairly and place the services where they are needed. With the improvement in medical science and services, there is an increase in number and proportion of older people (over 85 yrs) living in our community. Although people still have, or are incurring a disability during their life, people are living longer and therefore they need assistance for longer, placing more demand on services and providers. It is also imperative to provide services in a timely and targeted way.

Assessment and care planning has often focused on a person’s weaknesses and what they are unable to do, rather than focusing on strengths, capacity building and restorative care. In the past, when HACC provided supports to keep a person independent and at home, they may have inadvertently created dependence on support services. Traditionally, HACC services have been delivered in a task oriented way that comes from a ‘do for’ approach rather than a ‘support to do’ or ‘do with’ approach. It is hoped that by supporting the person to achieve their goals, there will be a different outcome.

Active service focuses and builds on the persons (and carers if applicable) strengths and abilities, and has an emphasis on improving their quality of life, social participation and connections. We know that by being active (mentally and physically), eating well and staying connected with family, friends and the community, people do not feel so isolated and alone. The incidences of mental health conditions such as depression are reduced, people are happier, have a sense of belonging and purpose, feel valued, build meaningful friendships and ideally have more fun and enjoyment in their lives.

The Active Service Model is based on the belief that people receiving a service have the potential to improve their capacity and wellbeing and that HACC services can assist to improve their ability to make an improvement in their lives. HACC understands that most people want to remain in their own homes for as long as possible and avoid early admission to supported accommodation. This approach was designed to assist people to live in the community as independently and autonomously as possible. When talking about Active Service, independence refers to the capacity of people to manage the day to day activities of their daily life and autonomy refers to making decisions about their life.

Not all HACC service recipients will be able to live in the community without some form of assistance, but the goal of this initiative is to ensure that people are able to gain the greatest level of independence they can, and equally, they can be as actively involved in making decisions about their life as they can be – such as the type of services they receive and the goals they wish to achieve.1


What the Active Service Model is Not

The active Service Model is NOT about taking services away from people who need them.
What is an Active Service Model Approach?
The Active Service Model approach can be defined as:

- Assuming that change is possible and meaningful
- Goals that are specific to the person, are achievable and are reviewed regularly
- Empowering individuals
- Open to challenge if the system is rigid
- Restorative
- Building strong collaborative partnerships that will benefit the person
- Open communication
- People having a voice – and being heard
- Doing with – not doing for
- Choices
- Encouraging independence and building confidence
- Seeing the whole person
- ASM is people-centred, not agency centred.
- ASM is a new way of thinking, not just a new way of doing.\(^2\)

If ageing is to be a positive experience, longer life must be accompanied by continuing opportunities for health, participation and security. Active ageing makes the most of these opportunities in order to enhance quality of life.\(^2\)


Person Centred Planning is:

<table>
<thead>
<tr>
<th>Person Centred</th>
<th>not</th>
<th>Staff Centred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning with</td>
<td>not</td>
<td>Planning for</td>
</tr>
<tr>
<td>Talking with the person</td>
<td>not</td>
<td>Talking about the person</td>
</tr>
<tr>
<td>Starting with what is important to the person</td>
<td>not</td>
<td>Starting with what’s wrong</td>
</tr>
<tr>
<td>Health and safety addressed</td>
<td>not</td>
<td>Health and safety dictate</td>
</tr>
<tr>
<td>Where the person wants to live</td>
<td>not</td>
<td>Where you live – with no inference of choice</td>
</tr>
<tr>
<td>Power is shared</td>
<td>not</td>
<td>Staff are ‘in charge’</td>
</tr>
<tr>
<td>Living Plans – change with the person</td>
<td>not</td>
<td>Dead Plans – ‘updated annually if at all’</td>
</tr>
</tbody>
</table>

How we see people:

<table>
<thead>
<tr>
<th>Capacities</th>
<th>not</th>
<th>Deficits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gifts and interests</td>
<td>not</td>
<td>Inabilities</td>
</tr>
<tr>
<td>Members / participants / person attending</td>
<td>not</td>
<td>Clients</td>
</tr>
<tr>
<td>‘All of us’</td>
<td>not</td>
<td>‘Not us’</td>
</tr>
<tr>
<td>Proud</td>
<td>not</td>
<td>Shameful</td>
</tr>
<tr>
<td>Need for assistance/support</td>
<td>not</td>
<td>Private troubles</td>
</tr>
</tbody>
</table>
**Well for Life**

Well for Life is primarily understanding and promoting the inter-relationship and benefits of good nutrition, physical activity, social participation and emotional wellbeing which supports and promotes independence and healthy aging.

Well for Life principles work very effectively and complement the ASM principles.

Well for Life focuses on and supports older people who participate in Home and Community Care (HACC) services, live in public sector residential aged care services (PSRACS) and live in public housing.

Well for Life is part of the Department of Health's priority of promoting physical and mental health, and wellbeing among older people. Well for Life has been operating in Victoria since 2003.

By developing and encouraging Well for Life principles and initiatives within your PAG, this may promote older people’s health and wellbeing, physical activity and emotional wellbeing. For example, combining fun and gentle exercise as a group activity in your program. At the Yarra Ranges Council, the Yarra Junction PAG have regular exercise sessions and this is made available to anyone in the group who wishes to participate.

Other examples include:
- Falls prevention programs
- Walk and Talk
- Strength training through gentle exercise

There is much laughter as the group exercises and it is obvious that everyone is enjoying the activity, plus they are gaining benefit from it. People are seated in two rows – the two rows facing each other. Staff improvise and give each person a “swimming noodle”, there is a person seated at one end who throws a balloon into the middle and then it is game on! Each team tries to get the balloon to the other end using their noodle. There is a small prize and much glory for the winning team. While superficially, the activity appears to be a great game it also incorporates and develops many other proficiencies such as mobility, coordination, communication and prolonged concentration.

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**Five dimensions of inclusion**

Written by John O’Brien

Ask any group of people what makes life worth living and what makes for a good life and they tend to say the same things. John O’Brien outlined the ‘five service accomplishments’ or the ‘five dimensions of inclusion’. These attempt to capture what makes a good life under five headings:

**5 Dimensions of inclusion:**
- Choice and control
- Belonging
- Contributing
- Sharing Ordinary Places
- Being Somebody

**Contributing**

We all have gifts and capacities. But as John McKnight says “gifts aren’t gifts until they are given.” Giving our gifts, and using our capacities, are important parts of living a full life.

**Being someone**

We all want to be noticed, to be valued by others. We want people to notice if we’re missing, to want to know our opinions, to see us as equals. We want people to care what we think of them.

**Belonging**

We all want to belong. To have friends, to be loved, to have people want to have us around. Belonging is about who we want to be around, and who wants us around. It isn’t what happens when we learn to cope with having been put with others (because they are seen to be like us). And belonging is about personal, not professional relationships.

**Sharing ordinary places**

None of us like to be put away, kept apart from the real world. It is in ordinary places that belonging and contributing matter to us. We want to be free, not locked away, or put aside.

**Choice and control**

We all want to be allowed to strive for our own unique identity and future. We want to have as much power over our destiny as other people, not to have others taking decisions for us – and when we need help we want to be in control of what happens not to be carried along in the current. Our individuality, our personhood, is not made up of just big things but also of our many tiny and seemingly insignificant decisions and preferences.

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Based on the work of John O’Brien, http://thechp.syr.edu/rsa.htm

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**What makes life worth living**

Family
friends
love
money
choices
hobbies
making a difference
being free
interests
being an individual
having people notice I’m there

---

**Family friends love**

having people respect me

money doing something worth doing

something to look forward to

holidays

my work

being free

excitement

having people notice I’m there

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**We want to be free, not locked away, or put aside.**

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22 PAG pathways > planned activity groups

version 2.2014
Active Service: A changing way for staff and volunteers to support people attending our PAG’s

Traditionally PAG staff and volunteers have stepped in where they saw a need or an opportunity to assist someone – and “did it for the person”. This was well meaning, the intention was to support and nurture, and frankly – sometimes it can be quicker to do it yourself.

People attending the group will have differing abilities, and this is where your skill and experience is valued and needed to discern when to encourage, motivate and support, and when to assist.

It is encouraging to see what people are capable of, or what they can learn when they are given the opportunity, the time, the skills and the support they require.

PAG staff and volunteers have commented that it will be challenging to step back, to observe first, to give people time to do things themselves – they are concerned it may appear they are not doing their job.

Encouraging and supporting people to be independent, and doing things which will increase their independence and capacity means you ARE performing your job.

People attending the program may notice a change and comment on being encouraged to do more themselves but you can introduce the changes slowly. It may take a little while for some to get used to doing more for themselves – but you ARE doing your job, and in time they probably won’t notice. It will be much easier for new members as they join the group.

Most of the principles come naturally to people who work or volunteer in PAG’s and when done effectively, the people attending our PAGs will benefit in many ways.

With the ASM, there is a shift:

From: “Doing FOR the person”
To: “Doing WITH the person”.

There is a risk that a person may not do something for themselves if someone else is going to willingly do it for them.

For example – this means the person may remain seated for most of the PAG which could result in:

- not socialising and engaging as much with others
- always sitting next to the same people
- not moving and exercising their bodies
- people not feeling encouraged or motivated to make suggestions and contribute
- not getting involved and just sitting back and allowing things to happen around them
- not learning / relearning skills that can assist people to remain independent
- it doesn’t encourage people to make their own choices and decisions

With the introduction and implementation of ASM, examples of an alternative approach would be:

- **Taking a step back** to encourage people to do things for themselves (and others if they wish – eg passing glasses of water to others on the table, coming up to the servery and assisting to serve plated meals, clearing dishes etc.)
- **Asking first** if the person needs assistance – not assuming they do
- **Offer choices** so the people attending the PAG can decide for example:
  - what activities they would like to do
  - what outings they would like to participate in
  - planning menu choices
- **Supporting people to order and pay for their own meals** when out etc;

Obviously some people attending the PAGs will have more capacity to contribute to the group and do things for themselves but with time, encouragement and support, everyone will be able to gain something from an ASM “way of life”.

Active and Inclusive Language

Something else to be aware of is a shift in the “language” we use in PAG’s.

There is a shift away from the term “client” and most PAG’s are already doing this. “Client” is most commonly used in a medical sense and can be perceived as condescending or the person using it having a sense of empowerment.

**Common alternatives include:**
- Person (attending the service)
- Member
- Participant
- Consumer.

**Examples of what types of things may be considered “Active and Inclusive”**

<table>
<thead>
<tr>
<th>What was the activity</th>
<th>Why is this Good Practice??</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members making choices about activities, menus, outings venues</td>
<td>choice, autonomy, services organised around the person, control over own life</td>
</tr>
<tr>
<td>Members assisting other members</td>
<td>Feelings of self worth, usefulness, self respect, an holistic approach</td>
</tr>
<tr>
<td>Changing the program to suit the members, or at a member’s request</td>
<td>Services organised around the person, autonomy, exercising choice</td>
</tr>
<tr>
<td>Building a members interests into the program</td>
<td>Holistic service, choices, service organised around the person</td>
</tr>
<tr>
<td>Encouraging people to try new things</td>
<td>Opportunity to improve capacity, holistic service, increase self esteem</td>
</tr>
<tr>
<td>Talking to each other, sharing information, talking to carers, adding to social profile with new information</td>
<td>A collaborative service, strong partnerships, good working relationships, better outcomes</td>
</tr>
<tr>
<td>Any exercise, weights, therabands, walking, brain gym</td>
<td>People can improve capacity, and maintain important skills</td>
</tr>
<tr>
<td>Accepting individual and building his routines into ours, allowing AV to be late or only come once a month</td>
<td>Services organised around the person</td>
</tr>
</tbody>
</table>
The Four Key Steps

Within the framework of the ASM, when supporting a person in your program, there are four key steps. Even when the person is established in the group, there will be ongoing review and assessment. The four key steps are:

1. Initial contact and assessment
2. Care planning (ongoing reviews)
3. Delivery of services and how they are delivered (can include Discharge from the PAG)
4. Review and reassessment

Initial contact and assessment

Assessment (which includes the intake and initial needs identification process) is critical to identifying opportunities to improve individual capacity, to deliver health promotion information, to advise on local support or service options, and to hear the person’s story. Assessment is not a one off event. It is an ongoing process of building a relationship with the individual (and carer) that begins at the first point of contact and continues through to service delivery, review and reassessment. There are two layers of assessment offered in HACC that can occur simultaneously or independently: service specific or Living at Home assessment.

Service specific assessment occurs when the person has fairly straightforward needs such as requesting to join a PAG or short term meals on wheels. The purpose of a service specific assessment is to identify specific requirements and develop a service specific care plan to meet the person’s goals. Service specific assessment may also be required when a person comes to the service following a fairly comprehensive assessment from another part of the sector such as ACAS or hospital.

Living at Home assessments (LAHA) are really designed for people who are new to HACC or present with a range of needs that have not been recently assessed. The purpose of a LAHA is to gain a broad understanding of the type and range of opportunities to maximise their ability to remain living in the community. A LAHA involves assessment broader that the service types being sought by the person and broader than the service types being offered by the assessing agency. Changes in existing HACC clients circumstances may also mean that they might benefit from a LAHA. For example, an existing PAG participant may benefit from a LAHA if their usual carer is no longer able to continue their current role.

Excerpts from presentation
ASM Industry Consultant, Eastern Metropolitan Region

Being aware of the ASM principles, when meeting, assessing and reviewing people wishing to attend your PAG, please keep in mind:

- what strengths and abilities the person has, not just what their needs are
- are there any supports the person needs to actively participate
- does the person have any needs, particular likes or dislikes to be aware of
- what goals would the person like to achieve at the group
- what makes coming to the group important to the person – it could be a combination of social, emotional and function needs (eg: to make or be with friends, to learn a new skill, to link into the community)
- discuss other opportunities for social participation
- are any supports or services needed for the person to achieve their goal
- whose cooperation is needed to make this happen – may need to be done in conjunction with carers/ support person and the PAG staff.
- is the person supported by a carer and can the PAG assist the carer through social and support groups.
- using approved processes / forms to capture all relevant information and an opportunity to embed principles of ASM
- dignity for the person around having some sense of control in their life
- being aware and maintaining their privacy
General PAG Referral and Assessment Flow Chart
(For non HACC Assessment Services)

PAG referrals received (By Intake and / or PAG Coordinator)

Contact is made with the person (or carer) to discuss the program and determine if the person is eligible for the program and meets HACC requirements

No

Refer to, or provide information on other suitable services / agencies

Yes

Intake or PAG Coordinator complete the applicable forms with the initial information

PAG Coordinator / Area Coordinator / Manager checks availability of the programs and arranges a home /social visit

Attend social / home visit and discuss likes, dislikes, needs and goals, and fill in Goal Directed Care Plan

Eligible

No

Provide person / carer with info. on other services / agencies

Yes

Remaining HACC / PAG and consent forms completed & signed. Mutually decide program / day that best suits the person / carer, if applicable, invite carer to attend initially to support the person. Care /Goal Plan commenced

Arrange transport if required

Advise staff and volunteers of the new person commencing, and plan for their introduction and orientation to the group or program

New person commences the Group

• Complete Care Plan with full consultation
• Ongoing regular review with the person and modify Care / Goal Plan as required. Eventually 6 – 12 month reviews

This is a guide only so please refer to the assessment procedures within your own organisation.
Social Profile / Care Plans

People use different terms for this document. For the purposes of this manual, we will be using the following social profile to capture all the information.

This is just a guide and although it is a comprehensive document, it is only necessary to complete the sections that apply to the person and your program. It is just a suggestion and you can amend it to suit your needs. Not every section needs to be completed for every person – just use the relevant ones.

The care plan is designed to also incorporate the ASM principles. There is an example of a Social Profile / Care Plan in this chapter.

This example was designed to:

• Gain an holistic knowledge of the person, not just the required information of name, address, contact information, medical information etc. but including the person’s likes, dislikes, interests, what works for them, option to describe how to best support the person (mobility, speech, capacity building etc) and goals etc.
• Opportunity to jointly set goals with the person (and carer if applicable) that are meaningful
• Identify services received and options for other referrals and connections
• Documenting the steps towards reaching a persons goals, which are specific, measurable, achievable, realistic and have a time frame (SMART) and outcomes that enable people to measure progress.
• And a review which is designed to:
  – monitor how the person is progressing towards their goals
  – opportunity to reassess the person if their needs and abilities are changing.

After the initial contact and assessment with a person, the second stage is creating a Social Profile / Goal Directed Care Plan.

This may include the involvement and contribution of several people – for example:

The person attending the PAG, if applicable their carer or a support person, the PAG Program Leader / PAG program workers and any other relevant person providing a service or support including if volunteers wish to have input.

The benefit of people being involved and setting their own goals within their care plan is they feel a sense of control, that it’s not all happening around them and they have a say in decisions. The person feels their needs, concerns, goals and opinions are valued and they are able to express what is important to them. There is often more commitment to working towards the goals if the person has direct input into the plan and they feel the goals are relevant and important to them.

The revised care plan assists to not only capture the traditional core information but also the essence and holistic picture of the person, and how the PAG can provide the best experience for them, and if applicable, their carer.

Following, there is an example of a care plan. Although it is a comprehensive document, it is only necessary to complete the applicable sections and you can amend it to suit the needs of the person and your program. The care plan is designed to incorporate the ASM principles and there are examples. An electronic copy can be obtained from Sarah Yeates at Caladenia Dementia Care www.caladenia.com.au and click on “resources”.

Although there are five principles of the ASM (listed previously in chapter 2) often there is no definite principle the information can be categorised into as it will often overlap, this is not a problem at all. In time, the ASM will become “second nature” as people become very familiar with the principles.

There is a matrix following on the next page that has examples of the five (5) ASM principles and where you would find questions / prompts within the care plan.

As an example, by working through the actual care plan document, you will be prompted for information about the person that helps form a detailed picture of the person and how the PAG can best support them (and the carer if applicable).

You will notice that the care plan covers not only their emergency contacts, alerts, medical and support needs but also seeks to gather a “holistic” picture of the person. It covers what is important to the person, what their goals are, who will assist the person to achieve them, what the timeframes are, review dates etc. Also, capturing information relating to other services that are supporting the person to remain at home so a collaborative approach is provided.
The Five Principles and how they relate to Goal Directed Care Plans and Care Planning

People want to remain autonomous
• Discussions at assessment around the person’s strengths interests and goals
• Allowing opportunities for independence, choice and control within the programs themselves

People have the potential to improve their capacity
• Exploring goals and reviewing goals regularly
• Listen to the person – what is it that they would like?
• Provide opportunities for people to try new activities, or tasks – within the broader scope of the program

People’s needs should be viewed in an holistic way
• Refer to social profiles and care plans frequently, not just at review
• Allow opportunities within the program for individual interests and skills to be utilized
• Keep the conversation going – with the person, their carer, family members....
• Make provision for more than just social activities – include physical activities, mental stimulation, cultural activities and spiritual activities.

HACC services should be organised around the person
• Which group would suit the person's strengths and abilities?
• Being flexible with days/times where possible to suit the person
• Offering a range of programs and regularly asking for input

Collaborative working partnerships and relationships
• Who else is important to this person?
• Are we in touch with other local services? (Community Health, Council, Physio, Cultural Agencies)
• Does the person have a carer? How can we support the carer to maintain this care relationship?

Example of a Social Profile

Goal Directed Care Planning
This is a section of the example care plan giving some ideas about how to fill in and complete the section around goals.

Goals (Incorporate an Active Service focus)
• please note, not everyone will be suited to having a goal.
• include as many goals and sub goals as required

Main Goal: To improve confidence and communication (speech) skills.

Steps towards main goal/s:
1: Gain confidence by participating and contributing in group discussions.
Emmy has been asked about her stroke and feels with support, she could give a short talk about her experience with the group.

2: Share examples and skills of sewing with the group. If others interested, Emmy to teach interested people.
Action/s Required: encouraging and supporting Emmy to participate in general discussions.
provide opportunity and time for Emmy to talk about her experience with the stroke

Goal: Make time to bring in her work
By date: 30 June 2012

Person Responsible: Christene Wilson

Step #1: Choose main goal

Step #2: Write steps which must be taken towards achieving this goal. These are your subgoals

Step #3: Write down the actions which are needed to achieve the subgoal

Step #4: Write down a date in which these actions plan to be completed.
### Example of a Social Profile (continued)

<table>
<thead>
<tr>
<th>PERSON</th>
<th>ACTION</th>
<th>TIME FRAME</th>
<th>OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joan</td>
<td>Attend Day Program at Happytown each Tuesday 10am – 3pm</td>
<td>Ongoing</td>
<td>Joans Commencing 1/7/14</td>
</tr>
<tr>
<td>Joan</td>
<td>Encourage Joan to participate in the group’s games program and cooking activities while attending the program</td>
<td>Ongoing</td>
<td>Kate 3/5/14</td>
</tr>
<tr>
<td>Kate &amp; Mary</td>
<td>Send referral to Helpful Harry Driving Service for volunteer driver to assist Joan travel to and from the group</td>
<td>Ongoing</td>
<td>Kate 5/5/14</td>
</tr>
<tr>
<td>Daughter Mary</td>
<td>Family to assist Joan with transport until Volunteer transport can commence (approx. 4 weeks)</td>
<td>Ongoing</td>
<td>Mary 1st 4 weeks</td>
</tr>
</tbody>
</table>

### PAG Service Delivery

For both new, and existing people attending, periodically review their social profile for goals so activities and outings can be arranged to support the interests and strengths and goals and people.

From the social profile / care plan, be aware of the “sub /soft goals” of the people, for example:
- to gain confidence in speaking to people (other than family) after a stroke
- Likes to be helpful and assist with serving drinks / meals to others
- likes to participate in memory games / activities as he is concerned about Dementia
- person attending a “Falls Prevention” group so encouragement to move unaided but watching for uneven surfaces, rugs etc.

On a regular basis discuss / survey the people attending (including volunteers) to know what activities and outings people are interested in doing, what have they enjoyed in the past, any they would like to do again, any topics of interest so a guest speaker could be invited (a list of suggestions could be prepared and discussed), what they didn’t enjoy, something new they would like to try, ideally include activities that that will assist in achieving the (measurable) goals for many of the people attending.

Being aware of the abilities of the group, mobility needs (is a hoist bus required for an outing ), any behaviours of concern, plan and arrange activities that are of interest and stimulating to the group – meaningful recreation. Outings can be for the full group or a smaller group if only about half are interested in participating.

Hold regular team meetings (including volunteers as approp,) and include: ASM as a regular agenda item – can be discussed briefly but keep awareness , provide ongoing training / discussions, incorporate in orientation (both people attending and volunteers). Keep volunteers informed & involved so they feel included and know how to best support the people attending. Acknowledge, document & celebrate positive achievements and outcomes.

Be constantly aware of the enabling approach of “Doing With” not “Doing For”

Liaise and network with other PAG’s to share experiences, positive outcomes (and the not so successful ones), what worked / what didn’t, comments & feedback on any evaluations.

Review program plans regularly (can get input from carers/ family members) and try to maintain flexibility and a variety of activities as practical, especially for PAG’s that run multiple groups.Being aware of any cultural, diversity or religious beliefs and considerations
Include opportunities for physical activity and social connections , and Well for Life principles where possible

Any carer needs / respite that the PAG can assist with

- Advise staff and volunteers of the new person and any requirements / supports required
- Ongoing regular review with the person and modify Care /Goal Plan as required.
Planning your program:

When planning your program, for both the long and shorter term, it is important to gain information on what the people attending your PAG are interested in and what activities and outings they would like to see included. This information can come from:

- Discussions with the group regarding
  - what activities or outings they have enjoyed
  - what they would like to do again
  - the activities or outings they didn’t enjoy
  - something new they would like to try
  - guest speakers and topics people would be interested in
  - feedback from staff and volunteers
- Care Plans
- Surveys
- Evaluations
- Team meetings
- Feedback from family members / carers / other people / clinicians involved in the person’s care.

When social profile and care plans are done comprehensively (as per example care plan in chapter 4) and reviewed regularly, the information gained helps to provide an holistic picture of both the person, but also any overall trends, interests, abilities and goals of the people attending your PAG.

For example several people:

- have emigrated from another country
- had farming backgrounds (either working on or grew up on a farm)
- love fishing
- interested in photography
- computers
- love travelling – especially cruises

By identifying this information, group discussions on the common interest topics can be held:

- encourage people to “tell their story”
- appropriate materials / resources can be provided
- outings could be arranged
- guest speakers on the topic etc can all be arranged.

Activities can be either for the full group or a smaller group activity for those interested.

People enjoy the activities much more when they are interested and will usually participate and gain more from their involvement, they are likely to feel more included and connected to the group. When people are stimulated by the company, activity and even the environment, they may feel encouraged and open to recall and discuss aspects of their past, discuss current events and generally be more engaged rather than just sitting passively and often disengaging from the group. It also helps with the unity of the group as participants learn more about each other, common interests are identified, a new friendship and perhaps a new found respect due to a person’s achievements or adventures / experiences.

There is a need to ensure flexibility and variety of the program as much as practical. Programs need to be reviewed and modified on a regular basis – one defined and set program won’t accommodate all interests and abilities, and will become boring for the people attending, as well as for the staff and volunteers.

Although this would be common practice for most PAG’s:

- being open to suggestions from people attending, carers, volunteers and other staff will ensure a range and diversity of options (not just agency driven as in the past)
- awareness of the goals of people attending – can these be included as part of
- either large or small group activities so the goals and interests can be addressed?
- Include opportunities for physical activity and social connections
- Exercises that include Activities of Daily Living (ADL) incorporated into everyday activities where appropriate.

Ideally, incorporating the above into your PAG will assist in meeting and achieving the (measurable) goals for many of the people attending whilst being enjoyable and assisting to maintain or build the capacity of people attending.

This may require some creative thinking and solutions to meet a range of the person’s and carer needs.

Be constantly aware of an enabling approach of doing “with” not “for” as much as possible whilst recognising that some people may still need supports and services.

Planning your program:

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This may require some creative thinking and solutions to meet a range of the person’s and carer needs.

Be constantly aware of an enabling approach of doing “with” not “for” as much as possible whilst recognising that some people may still need supports and services.

When planning and delivering your PAG program, it is worthwhile remembering the Components of Active Service:

- Considering the individual needs of people and thinking how they can be incorporated into the group. This may require looking “outside the square” rather than relying on what is typically done in the PAG or available.
- Embedding a “doing with not doing for” approach.
- The program being flexible and responsive to the needs of individuals whilst being aware of the changing needs of the group.
- Having an holistic approach to people attending (also extending to volunteers and staff).
- Creating opportunities for capacity building for people attending.
- Health promoting activities.
- Collaboration with other partners, agencies, services, social groups, activity groups, sporting groups and facilities, community service groups (Lions, Kiwanis etc.) etc.
- Social connectedness is equally important as all the above and incredibly important. For most people, becoming a member of a PAG brings a sense of belonging, being valued, being noticed, the opportunity to tell a story, doing something for others, to celebrate occasions and this is often what brings meaning to people’s lives.

When planning activities it is useful to consider the following questions:

- Do the activities align with the principles of ASM and WFL including emotional wellbeing? (see the end of chapter 1 for an explanation of Well for Life)
- Does the plan incorporate feedback from staff, volunteers, people attending and carers about past activities and preferences expressed for new activities?
- Is the plan responding to information about an individual member’s needs gathered during assessment?
- Does it create opportunities for companionship and friendship?
- Are activities designed to enhance daily living skills?
- Are the activities appropriate for the age of the people attending?
- Does it include and encourage appropriate levels of physical exercise?
- Is there a balance between social, intellectual and physical stimulation and between large group, small group and individual activities?
- Have different ideas for activities been sought from relevant publications and from other PAG providers?
- Does it provide opportunities for celebration of culturally relevant festival days, holidays or other celebrations, such as birthdays and anniversaries?
- Can the group participate in local community activities such as street festivals, art exhibitions, library activities, and concerts?
- Are people having fun and, at the same time, participating in activities that will maintain skills, such as hand/eye coordination?
Training for staff and volunteers

For new staff and volunteers, active service will be part of the induction.

For existing staff and volunteers, a specific PAG ASM training module has been developed which many people have attended and this training is also available to the wider HACC community through the HACC training calendar, which people can attend.

If you would like a copy of the training material, please speak to Sarah Yeates from Caladenia Dementia Care.

Phone: (03) 9727 2222
Web: www.caladenia.com.au
Email: caladenia@caladenia.com.au

Some of the feedback from participants who attended the training is included in this manual.

What are PAG Staff saying???

“People can probably do more than I think they can, and even more than they think they can”

“Encourage all people to have more involvement in the program where possible”

“Encouraging improvement in goal setting”

“Thinking about things from the person’s viewpoint”

“View each person holistically”

“Everyone has the potential to benefit from ASM”

“Every PAG has different needs and capabilities”

“Other agencies have the same issues”

“Network with other organisations for ideas and resources”

“Different activities for different groups”

“Always share (discuss) ideas – at the end of each day”

“We can continually think of new ideas”

“Encourage staff to build on their practice and capture ASM principles and achievements – to share what works with others”

“Reflective practice”

“Greater awareness”

“Validation of what we are already doing”

“Positive affirmations – choice of words for encouragement”

How staff and volunteers continue to be mindful of ASM within your PAG?

• Team meetings / combined PAG meetings to check on:
  – progress of other PAG’s
  – how teams achieved the outcomes
• Brainstorming exercises in meetings
• Regular item on agenda for team meetings:
  – can be discussed briefly but keeps the awareness
  – provides an opportunity for people to ask questions and to share the lessons – a way of providing ongoing informal training,
• Incorporate into program planning, activities and leisure planning

How can knowledge be available to other staff, volunteers and to future staff?

• Refer to this manual
• Evaluations from team meetings and training:
  – capture results of people
  – quality / quantify achievements
• Forums / feedback opportunities
• Provide a book to capture quotes and feedback from the people attending – easily accessible and available for all to write or draw in.
  Can contain memorable quotes, funny anecdotes, stories, significant happenings, comments and feedback, and events from the day.
• Acknowledge, document and celebrate positive occurrences, achievements and happenings
• Spread the ASM word to all volunteers
• Provide ongoing training
• Included in orientation
So. What are the benefits for people attending a PAG??

- People are likely to take more control and make decisions for their own life and become less dependent on others for their physical and emotional wellbeing.
- People are more connected with each other and feel less alone. Stress levels are reduced and feelings of isolation.
- People meet up outside the group either on the phone or in person.
- People love coming to the PAG, they feel connected to others, that they belong, they are noticed, special events celebrated and they have a say in the activities that are offered and planned.

So... what are the people saying??

✓ People generally embrace the concept
✓ Have a sense of motivation
✓ Value setting their own goals
✓ Not restricted by assumptions about what they can and can’t do
✓ Change their expectation about how HACC can assist them rather than “I am entitled”
✓ Like having more of a say

Tips comments

Most of the principles come naturally to people who work or volunteer in PAG’s and when done effectively, our members have much to gain.

A new way of PAG life. Doing with – not doing for

It’s ok to take a step back and allow the person to do more for themselves – it may take longer – but usually that’s OK.

Ask if someone needs assistance – people mean well but – don’t just assume they do.

It may take longer for a person to eat their lunch but they may prefer to do it themselves than feel disempowered or embarrassed having someone assuming they want their food cut up for them.

Most people are nurturers and want to take care of others – this is still the case but often we can help more by: observing, asking and listening first.

A Duty of Care still applies.

Capturing and Recording the Results

PAG book – easily accessible and available for all to write or draw in.

- PAG Book - a book for everyone to record anecdotes, comments, feedback and ideas.
- Forums - encourage feedback, ideas and comments in a formal or in formal forum setting
- Use staff meetings, volunteer meetings and carers meeting to “spread the word” explain what you are doing and why

Can contain memorable quotes, funny anecdotes, stories, significant happenings, comments and feedback, and events from the day. Document and celebrate achievements.

Forums / feedback opportunities

Chatting to the bus driver / jockey as they hear the discussion in the bus when dropping people home at the end of the program.

Reinforce the ASM word to all staff and volunteers through a regular agenda item at meetings – can be discussed briefly but keep the awareness and acknowledge and celebrate positive occurrences and happenings – everyone likes a good story.

Provides an opportunity for people to ask questions and to share the lessons. A way of providing ongoing informal training.

How will we know if we have been successful in implementing an active service focus?

(Predominately taken directly from responses from PAG staff and volunteers from the ASM PAG Pathways Training day)

- Good feedback from the people attending – members and volunteers
- Positive feedback from carers
- You hear people say they have enjoyed their day
- Good attendance / people comeback to participate in the program
- Long term members
- People are doing more
- People have input into the group
- They invite others to attend the group / spread the word
- Attendees being proactive in doing the things they can
- People progressing well in their goals
- Social connections are developed
- People feel part of the group – sense of belonging
- Ask for the activity to be repeated
- Positive and active discussion amongst themselves
- Chatting to the bus driver / jockey as they hear the discussion in the bus when dropping people home at the end of the program
- Smooth and effective transition in and out of the PAG
Discharge from a PAG service
- Person / Carer Initiated Discharge

PAG Discharge Initiated by Person (Carer) attending

PAG Coordinator is advised person will be leaving

The person / carer is offered support in their move to another service or care provider. With appropriate notice, discharge can be well planned, work out time lines, opportunity for a farewell as this is important for the person and others at the PAG.

If appropriate, discuss the reason/s the person is leaving as the feedback – both positive and any negative feedback is important, it can influence the future planning of the program and people attending. Could ask if the program met their needs/wants, expectations etc., if person does not want to discuss, this needs to be respected.

If a sensitive case, the Coordinator needs to be confident the person:
  - Is able to make or agrees with the family / carers decision to leave
  - Has access to appropriate support networks and services when they leave

With consent, liaise with the new service to assist with the transition.

With consent, advise staff, volunteers and the other members of the PAG that the person will be leaving.

Gain consent to send appropriate information to the new service. If the person has created a personal profile memory book this can be given to the person or forwarded to new service to assist with smooth transition (likes, dislikes, what works for me etc.).

If the person is going to local (within catchment area) Residential Care, consider if possible (and appropriate) to offer a limited period of transitional support period which enables the person to continue to attend the PAG (at the discretion of those involved)

As appropriate, hold farewell celebration for the person

From feedback from the person / carer leaving the PAG, if applicable review PAG policies, procedures, or activities (including days / age and gender mix etc.)

Discharge and Discharge Planning in an Active and Inclusive Way

All people (and their carers) leaving a PAG, should be offered support in their move to other care arrangements. When appropriate notice is provided, the discharge and the transition to other care arrangements is supported and planned. With consent, appropriate personal information can be forwarded to the new service. In addition, also with consent, a personal profile (what works for the person, preferences, likes, dislikes, interests, triggers etc) can be forwarded to the new service to assist the person with their transition.

People attending the PAG may initiate their own discharge and as mentioned above, where possible, discharges should be planned to ensure a smooth transition from one service to another. When someone leaves a group, the needs of other members, the staff and the volunteers also need to be considered as strong friendships are formed over many years and the opportunity to say goodbye can be very important.

Discussion should be held with the person choosing to leave (and their carer if applicable) regarding the reasons for leaving, did the program meet their needs/wants, expectations etc. as all feedback is valuable – including both positive and negative. Their feedback may highlight important issues for the organisation and therefore could influence program planning and activities (including days the PAG offered / age and gender mix – a men’s or women’s group, a younger person’s group etc) and worth considering if your service has the capacity to do this – would a greater number of people’s needs would be met this way. Policies and practices may also be reviewed in the light of their feedback.

People may choose not to discuss their reasons, and this choice should be respected.

If the person or their carer is dissatisfied with the service, if appropriate, it is important to ask them to clarify which particular aspect/s of the service they were dissatisfied with, so that you can attempt to improve this for others. In your discussion it may be worthwhile to also ask questions about staff member/s; activities; the mix of people in the group; whether they felt safe and comfortable at the centre. If the person is dissatisfied with any of the above aspects, there may be important implications for a range of organisational policies and practices. If the person or their carer has unrealistic expectations of the service, it is important to review whether information provided at assessment and orientation contributed to these expectations.

In some sensitive cases you will need to be satisfied the person has made or agrees with the decision made by a family member or carer to leave the program, and that they have access to appropriate support networks and services when they leave.

Naturally there will be many reasons that a person / carer decides to leave a service and these can include:

- Moving to another geographical area
- The needs of the person have changed
  - the person may increase their capabilities and would like to try something else such as volunteer work, paid work, participate in a special interest group etc.
  - the person’s health may deteriorate and they require a higher level of support
  - the person may move into residential care

With the person’s / carer consent, liaise with the new service to assist with the transition. Also send any relevant personal information and if the person has a memory book / personal profile book that could assist them to settle into the new service.

With consent, advise the staff, volunteers and other people attending the PAG that the person is leaving.

Some programs offer an option to the person if they are moving into local residential care, of a six week transitional support period (or longer at the discretion of the Manager). This enables the person to continue to attend the program whilst adjusting to their new home environment.

Discuss arrangements for a farewell for the person.

Depending on the feedback received from the person, it may be beneficial to review the PAG policies, procedures, or activities (including days the PAG offered / age and gender mix etc.)

As previously mentioned, if person does not want to discuss, this needs to be respected.

From feedback from the person / carer leaving the PAG, if applicable review PAG policies, procedures, or activities (including days / age and gender mix etc.)

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Depending on the feedback received from the person, it may be beneficial to review the PAG policies, procedures, or activities (including days the PAG offered / age and gender mix etc.)

As previously mentioned, if person does not want to discuss, this needs to be respected.

From feedback from the person / carer leaving the PAG, if applicable review PAG policies, procedures, or activities (including days / age and gender mix etc.)
Discharge from a PAG service
- Organisation / Service Initiated Discharge

PAG Discharge Initiated by the Service or Organisation.

- Decision to discharge a person from the PAG is made against the eligibility criteria for the Service – must be fair, clear, consistent and transparent.

Discuss sensitively with the person (and carer if applicable) and provide reasons for the decision, and information on their right to appeal the decision and/or use an advocate.

Option to assist and send referral to a more appropriate service.

When the decision is agreed by all parties, discharge planning should commence.

- Written notification of discharge, the process and time lines given to the person / carer

Gain consent to send appropriate personal information to the new service. If the person has created a personal profile memory book this can be given to the person or forwarded to new service to assist with smooth transition (likes, dislikes, what works for me etc.)

With consent, advise staff, volunteers and the other members that the person will be leaving.

If the person is going to local (within catchment area) Residential Care, consider if possible (and appropriate) to offer a limited period of transitional support period which enables the person to continue to attend the PAG (at the discretion of those involved)

As appropriate, hold a farewell for the person, involving people attending the PAG, staff and volunteers and family.

As a result of the person leaving and feedback from discussions, if applicable, review PAG policies, procedures, and activities.

To recap, as mentioned previously in this chapter:

- With notice, the discharge and the transition to other care arrangements can be well planned
- With consent, the person’s personal information can be forwarded including any memory books or personal profile information that may assist.
- The Coordinator should inform the person and/or carer of discharge process and time lines in writing. Written notification is given to the person or their carer.

There are a range of reasons the organisation may need to initiate a person’s discharge and these include:

- Admission to a Nursing Home or Hostel for permanent residential care
- Persistent non attendance by the person despite every effort being made by staff and carer to encourage the person to attend.
- Decline in the person’s physical condition to a degree where either frailty or the need for staff assistance become excessive and seen as a detriment to a person’s welfare and group functioning
- Where persistent physical aggression poses a serious risk to other members and staff or disruptive behaviour is seen to be detrimental to the stability of the group.
- When the person persistently wanders from the Day Centre and cannot be safely managed within the facility.
- When incontinence can no longer be managed despite appropriate interventions, and becomes unacceptable to other group members and staff.
- When behaviour constantly is deemed inappropriate by other group members (eg. bad language, lack of social graces etc) after reasonable communication with member.
- The organisation only runs sessions for core (low needs) groups, and the person has moved to a complex or high needs category, the person should move to a PAG for people with complex needs or another care management option.
- The person has moved and transport access is not able to be addressed.
- The person becomes ineligible for HACC services.

When the organisation determines that the person is no longer eligible for the service, the decision for an organisation-initiated discharge needs to be made against the eligibility criteria for the service, and ensure they are fair, clear, consistent and transparent.

The Coordinator needs to provide the reasons for the decision to initiate discharge to the person (and carer) and should be discussed sensitively. The person (and/or carer) should also be reminded of their rights to complain, lodge a grievance or engage an advocate.

The person (and their carer) has the right to appeal the decision of the PAG regarding discharge. Discussion should be held with the Manager / Coordinator and the person (and carer if applicable).

If no consensus can be reached – the person / carer have the right to appeal to an external party – the Department of Health or the person / carer may choose to use an advocate at this time.

When the decision is agreed by all parties, discharge planning should commence.

During the discharge process, if appropriate, the Coordinator could discuss the option of referral to a more appropriate service. Should this referral be agreed upon by the person / carer, with their permission, a referral can be made. People (and their carers) leaving a PAG, are offered support in their move to another service or organisation.
List of services that may assist PAG workers and volunteers to support attendees and carers

**General**

**Aged and Community Care Information Line**  
Ph 1800 500 853

**Alzheimer’s Australia Vic**  
Riversdale Road Hawthorn  
Education, Carers Support, National Dementia Helpline, Living with Memory Loss Program, mailing list and a newsletter  
Ph 1800 100 500

**Australian Government – Dept of Veterans Affairs**  
Ph 133 254  
Ph 1800 555 254  
Homecare and support:  
Email: GeneralEnquiries@dva.gov.au  
www.dva.gov.au/benefitsAndServices/homecare/Pages/homecare.aspx

**Commonwealth Carelink Centres**  
Ph 1800 052 222

**Department of Health**  
General enquiries  
Ph 1300 253 942  
Mobile callers  
Ph 9096 9000  
Website: www.health.vic.gov.au  
Email: enquiries@health.vic.gov.au

**Direct 2 Care**  
One-to-one aged care advice.  
Ph 1300 121 121

**National Dementia Helpline**  
Ph 1800 100 500  

**The Salvation Army**  
Salvo Care Line  
Ph 1300 36 36 22  
www.salvos.org.au

**Seniors Online**  
Is a new Victorian government website for older people.  

**Aged Care Services**

**Aged care Australia**  
Department of Health and Aging  
Ph 1800 200 422  
www.agedcareaustralia.gov.au

**Aged and Community Care Victoria**  
 ACCV exists to promote, encourage and assist the health and care needs of aged and community care clients by providing Members with accurate and relevant information, services, advice and leadership.  
Email info@accv.com.au  
www.accv.com.au  
Ph 9805 9400

**Aged Care Assessment Service (ACAS)**  
Ph 9764 6390

**Carer Services:**

**Carers Victoria**  
Level 1, 37 Albert Street, Footscray 3011  
Ph 1800 242 636  
Ph 9396 9500  
TTY 9396 9587  
Website: www.carersvictoria.org.au  
Email: reception@carersvictoria.org.au  
Carers Victoria is the statewide voice for family carers, representing and providing support to carers in Victoria. Carers provide care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or who are frail aged.

**Commonwealth Respite and Carelink Centres**  
Ph 1800 059 059

**Legal and Aged Care Services**

**Consumer Action Law Centre**  
Ph 1300 881 020  
www.consumeraction.org.au

**Consumer Affairs Victoria**  
Ph 1300 558 181  
www.consumer.vic.gov.au

**Council of the Aging (COTA)**  
Ph 9654 4443  
www.cotavic.org.au

**Elder Rights Advocacy**  
Ph 1800 700 600  
www.agedrights.asn.au
Seniors Information Victoria
Ph 1300 13 50 90

State Trustees
Can assist with financial planning, wills, advice on powers of attorney etc.
Ph 9667 6466
Or for residents outside the Melbourne metropolitan area.
Ph 1300 138 672
www.statetrustees.com.au

Victorian Legal Aid
Ringwood Ph 9259 5444
Melbourne Ph 9299 0234
www.legalaid.vic.gov.au

Respite Information

Consumer Directed Respite Care
Ph 1800 200 422

Aged Care Australia, Department of Health and Ageing
Email: agedcare.website@health.gov.au
Website: http://www.agedcareaustralia.gov.au/
internet/agedcare/publishing.nsf/content/CDRC-1

Government Funded Respite for Carers
– Commonwealth Carer Respite Centres
Ph 1800 059 059
Can provide: Carer Support Worker – someone to organise respite for you, and co-ordinate it. Funding to pay for carers either in the home, out of the home, provides transport etc (Up to $5000 per year)

Useful Resources

Victorian HACC active service model discussion paper and Implementation plan 2009-2011
(Department of Health, 2010)

ASM Prepare
Section 3: Practice Review and Planning Tools

CommunityWest, Wellness Approach

www.silverchain.org.au/research-projects/

Aged & Community Services SA & NT Inc
– The Better Practice Project
www.agedcommunity.asn.au/education_events/Better-Practice-Project.php

ECH – enabling older people to enhance their independence and enrich their lives
www.ech.asn.au

Older and Wiser:
A useful guide to common legal issues for older residents in the Yarra Ranges. Available from Eastern Community Legal Centre.
Ph 9762 6235
Or
Yarra Ranges Council
Ph 1300 368 333
Forms

Each organisation will have their own forms but the forms to consider having easily available include:

1. Social Profile Example
2. Goal Directed Care Plan Example
3. Permission To Photograph
4. Incident Report Example
5. Carer Survey Example
6. Daily Program Sheet Example
7. Client Carer Consent Form Example

Electronic copies of these forms and more are available at www.caladenia.com.au/resources
# Personal Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Home Phone: Mobile:</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Country of Birth</td>
</tr>
</tbody>
</table>

# Emergency Contact

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Phone: Mobile:</th>
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</thead>
<tbody>
<tr>
<td>Relationship</td>
<td></td>
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</tbody>
</table>

# Program

<table>
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<th>Days</th>
<th>Fee</th>
<th>Transport Required</th>
<th>Pick Up Time:</th>
<th>Drop Off Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mon</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

# Communications

- Non-verbal
- Speech Difficulty - please describe: ___________________________________________________________
- Communication Aid - any specific information: _______________________________________________________
- Preferred language: English Other (please specify): _______________________________________________________
- Interpreter Assistance Required: Yes No
- Hearing difficulty - any specific information: _______________________________________________________
- Wears glasses Other vision impairment (please specify): ___________________________________________________
- Any other specific information / instructions: _______________________________________________________

# Mobility

- Independent
- Ability to access car
- Walking stick
- Walking Frame
- Wheelchair
- Minimal assistance required
- Moderate assistance
- Supervision only
- Any other specific information / instructions: _______________________________________________________

# Allergies

- Food
- Plants
- Other (please specify): ___________________________________________________________
- Please provide specific information / instructions: ___________________________________________________

# Diet

- Vegetarian
- Gluten Free
- Other: ______________________
- Needs prompting
- Requires food cut-up
- Likes: ______________________ Dislikes: ______________________
- Additional comments: ___________________________________________________________

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# Medical / Medication

- Diabetes
- Epilepsy
- Asthma
- Other - please specify: ___________________________________________________________
- Any other relevant medical conditions / history or alerts: ____________________________
- Medication being taken: Manages medication independently Carer manages medication Requires prompting / assistance
- Medical alerts requiring immediate response / specific instructions: ____________________________

# Continence Management

- Not Applicable
- Independent
- Assist with clothes only
- Supervision only
- Prompting / direction
- Specific instructions: ___________________________________________________________

# Diets

- Vegetarian
- Gluten Free
- Other: ______________________
- Needs prompting
- Requires food cut-up
- Likes: ______________________ Dislikes: ______________________
- Additional comments: ___________________________________________________________

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- Medical alerts requiring immediate response / specific instructions: ____________________________

# Continence Management

- Not Applicable
- Independent
- Assist with clothes only
- Supervision only
- Prompting / direction
- Specific instructions: ___________________________________________________________

# General

- Cultural background: ____________________________
- Social and family history: ____________________________
- Other relevant information (e.g. what works / doesn’t work for the person – anything that may distress the person): ____________________________

---

Social Profile Example Continued
### Planned Activity Group Social Profile and Care Plan

#### Cultural / Religious specific requests

<table>
<thead>
<tr>
<th>Request / Comment</th>
<th>Strategy</th>
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#### Access to Home

- [ ] Dirt
- [ ] Pot Holes
- [ ] House numbered clearly
- [ ] Deep gutters
- [ ] Gate easy to open
- [ ] Safe parking
- [ ] Overhead clearance for bus
- [ ] Turning area
- [ ] Width clearance
- [ ] Pathway safe to door
- [ ] Dogs / pets to be aware of: ___________________________________________
- [ ] Unsafe access: _____________________________________________________________________________________

Specific instructions: ____________________________________________________________

#### People / organisations assisting with Care

<table>
<thead>
<tr>
<th>Other service</th>
<th>Currently receiving</th>
<th>Required</th>
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<th>Name</th>
<th>Type of Support</th>
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* If referral to further care is required, please notify PAG Coordinator

#### Previous Interest and hobbies

(Can include past employment, voluntary, military service, travel, sports etc)

#### Current Interests and hobbies

(What does the person enjoy doing?)

#### Strengths and weaknesses:

________________________________________________________________________________________________________

________________________________________________________________________________________________________

#### Is there anything the person needs support with / would like to learn?

________________________________________________________________________________________________________

________________________________________________________________________________________________________

#### Goals

- Please note, not everyone will be suited to having a goal.
- Include as many goals and sub-goals as required.

Step 1: Choose main goal.

Step 2: Write steps which must be taken towards achieving this goal – these are your sub-goals.

Step 3: Write down the actions which are needed to achieve the sub-goal.

Step 4: Write down a date in which these actions plan to be completed.

#### Main goal:

<table>
<thead>
<tr>
<th>Sub-goal #1:</th>
<th>Action/s Required:</th>
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<td>By Date: / /</td>
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<table>
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<tr>
<th>Sub-goal #2:</th>
<th>Action/s Required:</th>
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<td>By Date: / /</td>
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<table>
<thead>
<tr>
<th>Sub-goal #3:</th>
<th>Action/s Required:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>By Date: / /</td>
</tr>
</tbody>
</table>
Planned Activity Group Social Profile and Care Plan

Enactment of Personal Emergency Plans

- Do you have a personal emergency plan? □ Yes □ No
- If there is a plan, do you intend to: □ Yes □ No
- If planning to leave, do you have available transport and are able to leave? □ Yes □ No
- Do you have somewhere to go out of the area and which is safe (friend or relative)? □ Yes □ No

Name of person:
Contact phone number/s:

If your PAG group is on an outing and due to unforeseen circumstances the group are unable to return to their local area, do you have a plan? □ Yes □ No
Is there someone who could come pick you up from a meeting point? □ Yes □ No

Name of person:
Contact phone number/s:

If no plan is developed, discuss options and explore a realistic and feasible plan that the person / carer may be able to prepare and enact. If there are any concerns about this person’s emergency plan or their ability to enact this plan, please refer to PAG Coordinator.

Comments or further instruction: __________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Consent

- The person attending had been made aware of other Council services, as well as other agencies and support services.
- The person attending has been given information about their rights and responsibilities; including privacy, right to an advocate, and the complaints process, and this was discussed with them.

Person attending / Carer’s name: __________________________ Signature: __________________________
Program worker’s name: __________________________ Signature: __________________________
Review date: __________________________

Goal Directed Care Planning Template

Name: __________________________ People Involved: __________________________

WHAT DO YOU WANT TO ACHIEVE BY WORKING TOGETHER?

CURRENT SITUATION GOAL ACTIONS PERSON RESPONSIBLE TIMEFRAME COMPLETED OUTCOMES

Care plan provided to:
Client Yes / No
Family / Carer Yes / No Name/s: Client Consent: Yes / No
Other Staff: Yes / No Name/s: Client Consent: Yes / No
Other Services: Yes / No Name/s: Client Consent: Yes / No

Client Acknowledgement:
I understand and agree to this care plan.
Client: __________________________ and / or Carer: __________________________

Consent

I understand and agree to this care plan.
Client: __________________________ and / or Carer: __________________________
Permission to use Photograph

I, ____________________________, the adult named below, agree to and provide permission for (insert agency name) to use the photograph of me for use in (insert purpose), which may result in both hard and electronic copies.

I acknowledge and agree that ownership of any photographic recording will be retained by the (insert agency).

I authorise the use or reproduction of any photograph referred to above for publications and printed matter within the discretion of the (insert agency) without acknowledgment and without being entitled to remuneration or compensation.

I understand and agree that if I wish to withdraw this authorisation, it will be my responsibility to inform (agency) on (phone number), who will then inform any other two agencies involved. I understand the nature and the consequences of what is being proposed in the above paragraphs.

Date: ______ / ______ / ______ Signature: ___________________________________________________________

On behalf of ____________________________________________________________________

Name (Block Letters): ____________________________________________________________________

Address: ____________________________________________________________________

Contact Phone Number: ____________________________________________________________________

RETURN TO: (name and address)

Incident Report Example

(Agency Name) Incident Form

Date: __________________________________________________________

Name: __________________________________________________________

Position: _________________________________________________________

Incident Report: (Please include the time of the incident, and where the incident occurred, as well as actions taken, witnesses, and the need for any follow up.)

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(Please turn over the page if you need more space)

Signed: _____________________________________________________________________________

Manager Signature: ___________________________________________________________________

Date: _______________________________________________________________________________
Carer Survey Example

Carers Survey (Date)

Here at (name) we are committed to providing the best possible care and we are always looking for ways to grow and improve. We rely on your feedback, and your opinions are valuable to us. If you would rather provide feedback by phone or in person – please let us know.

1. What is it that you hope to get from the services at [agency name]?

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2. What else could we do to support you more appropriately?

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

Are you getting this? (1 = Not at all, 5 = Partially, 10 = Yes definitely)

1 2 3 4 5 6 7 8 9 10

3. What other programs or activities would benefit you? Be helpful for you?

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

4. On a scale of 1—10 (where 1 is not at all and 10 is definitely), how much do you agree that the staff and volunteers treat you with dignity and respect?

______________________________________________________________________________________________________

______________________________________________________________________________________________________

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5. It is really important that we stay in contact with you and seek your feedback. On a scale of 1—10 (where 1 is not valuable and 10 is very valuable) how valuable are the following communication tools:

<table>
<thead>
<tr>
<th>Carer Meetings</th>
<th>1</th>
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6. Do you attend carer support meetings? Yes No

If Yes: What is the most valuable thing about the meetings?

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

7. How do you get to [agency name]?

If you use the Bus—how valuable is this service on a scale of 1 to 10? (Where 1 is not valuable at all and 10 is very valuable)

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If you use another method to get to [agency name]—how valuable is this service on a scale of 1 to 10? (Where 1 is not valuable at all and 10 is very valuable)

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8. Which days / programs do you use at [agency name]?

What is the best thing FOR YOU about the programs that you utilise?

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

What is the best thing FOR YOUR RELATIVE about the programs that you utilise?

______________________________________________________________________________________________________

______________________________________________________________________________________________________

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If you could change anything about the programs or services provided to you—what would that be?

______________________________________________________________________________________________________

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9. On a scale of 1 to 10 (where 1 is not confident at all and 10 is very confident) how confident are you that you could ask staff at [agency name] about other services available for you or your relative?

______________________________________________________________________________________________________

______________________________________________________________________________________________________

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______________________________________________________________________________________________________

10. Would you like a follow up phone call from us? (Please leave your name and phone number)

______________________________________________________________________________________________________

______________________________________________________________________________________________________

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______________________________________________________________________________________________________

We value your privacy. All your information will be kept confidential, and feedback will not affect any services that you receive. Thank you for your time. Please return this survey to (name and contact details).
(Agency Name) – Consent Form

(AGENCY NAME) ATTENDANCE CONSENT

I, ______________________________ , being primary carer for ______________________________ , give my consent for the following events.

• I give my consent for her / him to attend (Agency Name) on a mutually agreed upon day(s). I also consent to her/him participating in outings and activities.

• I understand if there is an emergency, the appropriate emergency services will be contacted. I will be informed if this occurs.

• I give my consent for her / him to use (Agency Name) transport to and from the Centre and / or for outings and activities occurring away from the Centre.

• I give my consent for (Agency Name) to use his/her personal information, with identifying details removed, for use in statistical data. I understand that (agency name) and other funding bodies and Government Agencies may use this information, where this is legally permissible.

• I understand that an individual goal directed care plan will be formulated for him / her, and that I may request a copy of his / her care plan at any time. This care plan will be regularly updated and reviewed, and I will have the opportunity to have input into these reviews at any time.

• I understand that photographs may be taken of him / her during their time at the centre. (Please sign here if you agree for photographs of him/her to be used in newsletters / local paper / community displays / website / facebook page etc.)

Please use photos ______________________   Please do not use photos ______________________

Client Carer Consent Form Example

Daily Program – (Day)

Highlight / Theme: ______________________________

Day & Date: __________________________________   Lunch __________________________________

Afternoon Tea Preparation: ______________________________

Members: ____________________________________________

____________________________   Total: ______________________________

Orientation members: ______________________________

Absent: ______________________________

Staff & Volunteers (incl students): ______________________________

Bus (am) _________________________________________   Bus (am) _________________________________________

9:45 am: Briefing: __________________________________

10:00 am: __________________________________________

11:00 am: __________________________________________

Lunch: _____________________________________________

1:30pm: _____________________________________________

2:30 pm: _____________________________________________

3:30 pm: _____________________________________________

Costs? Special Instructions? Individual Member Needs?

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

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Petty cash taken:

Petty cash spent:

Daily Program Sheet Example
Commonly used Acronyms:

- ACAS: Aged Care Assessment Service
- ADASS: Adult Day Activity and Support Services
- ASM: Active Service Model
- ATSI: Aboriginal and Torres Strait Islander
- CACP: Community Aged Care Package (commonly known as CAP’s package)
- CALD: Culturally and Linguistically Diverse
- CHS: Community Health Service
- DH: Department of Health (Victorian)
- DHS: Department of Human Services
- DSR: Disability Support Register
- EACH: Extended Aged Care at Home (package)
- EACHD: Extended Aged Care at Home Dementia Program (package)
- HACC: Home and Community Care
- HARP: Hospital Admissions Risk Program
- HAS: HACC Assessment Services
- ISP: Individual Support Package
- NGO: Non-government organisation
- OHS: Occupational Health and Safety
- PAG: Planned Activity Group
- PCP: Primary Care Partnership or Person Centred Planning
- RDNS: Royal District Nursing Service
- SCTT: Service Coordination Tool Template
- VSDP: Victorian State Disability Plan

For further information, please refer to the Planned Activity Groups Section of the Victorian Home and Community Care Program Manual 2013