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<b>Service Stream</b>	Families and Young People Services	<b>Category</b>	Residential Care and Transition Services
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## 1. Scope

This Practice Paper provides a detailed guide for Care Team Leaders (CTL's) engaging in therapeutic programming within the Mercy Community (MC) Residential Care and Transitional Services (RCaTS) Client Management System (CTARS).

This guide includes detailed information for completing the Client Profile within CTARS, producing Data Analysis Reports and the development and maintenance of therapeutic care planning documents. This document is designed to be used as an initial learning guide and ongoing reference outlining expected interactions with client information, and therapeutic planning and outcomes for the people we support within the RCaTS programs.

It is expected that this guide is used in conjunction with other therapeutic Practice Papers to inform best practice and alignment to MC Program Overviews.

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## 2. Client Profile

All RCaTS client information is stored within CTARS. This includes static unique client information and data entered connected to the people we support's experiences and interactions. Within CTARS, the Client Profile is located within the [Admin](#) navigation bar under [Clients](#). Each person we support (referred to as a 'client' within CTARS) has their own profile which CTLs hold responsibility to create and maintain. Once a person we support has been entered into CTARS, a Client Profile (refer to *FS PROC RCaTS Referral and Suitability Matching*) will be present and available to edit and view. To develop the person we support's Client Profile, the CTL is required to enter the Profile via the [Edit Action](#) associated with the specific person we support. The following section provides direction and instruction regarding completing the person we support's [Client Profile](#).

### Creating, Deactivating, and Reactivating a Client Profile

To create a Client Profile; login to CTARS, select [Clients](#) from the main menu and then [Add Client](#). This will allow data input into the Client Profile as outlined in the Personal Details section below.

To deactivate a Client Profile; login to CTARS, select [Clients](#) from the main menu and search the name of the person we support to be deactivated, and click the [Deactivate](#) button.

To activate an inactive Client Profile, login to CTARS, select [Clients](#) from the main menu and select [Inactive Clients](#). Search for the person's name. Once located, select client, and then [Activate Client Profile](#).

### My Profile

The 'My Profile' section holds demographics, critical medical and behavioural alerts, contact/stakeholder details and information regarding legal orders. The following tables provide information and direction to support the correct data entry and profile development.

#### Personal Details

CTARS Field Name	Type of information for Field	Information Category
Profile Photo	Select the <a href="#">Select Image</a> button to upload a profile image of the person we support. This should be a .jpg or .png file. Images need to be updated every six (6) months or if the person we support's appearance noticeably changes (such as distinct change in hair colour).	Mandatory Information
Date of Photo	The date the current profile photo was taken. This is to ensure that the image is recent and has been updated in the correct timeframe.	Mandatory Information
Title	Miss, Mr., Master, Ms., Mrs.	Mandatory Information
First Name	As per birth certificate.	Mandatory Information
Middle Name	As per birth certificate.	Desirable Information
Last Name	As per birth certificate.	Mandatory Information
Additional Names	If the person we support has other names they are known by, select the <a href="#">Add Additional Name</a> button,	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	complete all fields, and save. Enter the person we support's preferred name in this section.	
Name Type	Select from the dropdown box. Ensure the 'Preferred Name' option is completed for each person we support, as this information is included in several reports.	Mandatory Information
Name	Enter the related person we support's name.	Mandatory Information
Birth Sex	Select the most appropriate of either Female, Male or Other. <i>Note: Required information for Quarterly Reporting.</i>	Mandatory Information
Date of Birth	As per birth certificate. <i>Note: Required information for Quarterly Reporting.</i>	Mandatory Information
Age	Auto fill.	Mandatory Information
Estimated Date of Birth	Select 'Yes' or 'No' depending on if the Date of Birth has been estimated.	Mandatory Information
Deceased Date	Leave empty if not deceased.	Non-mandatory Information

### Client Alerts

CTARS Field Name	Type of information for Field	Information Category
Client Alerts Enabled	Tick this box.	Mandatory Information
Client Alert Details	Enter the high risk/critical information that the Residential Care Worker (RCW)/Care Team must be aware of when interacting with the person we support. This information should reference where the Care Team member can access additional information regarding strategies and interventions rather than include the strategies in this section. This section should be kept short and current. This information will present in the On-Call Report and will indicate on the Client Profile name via a red (!) symbol. Examples: <ul style="list-style-type: none"> <li>Physical Aggression – High Risk of physical aggression, refer to Positive Behaviour Support Plan/Safety Plan;</li> <li>Self-harm – Medium Risk, refer to Positive Behaviour Support Plan/Safety Plan;</li> <li>Critical no-contact approved for X; or</li> <li>Challenges meeting new RCW – ensure introduction is completed.</li> </ul>	Mandatory Information (if current alerts present)

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## Critical Medical Information

CTARS Field Name	Type of information for Field	Information Category
Add Diagnosis	If the person we support has any diagnosis, enter via clicking the <a href="#">Add Diagnosis</a> button. When entering the information, click on the <a href="#">[?]</a> for help text.	Mandatory Information
Diagnosis Type	Select from the drop-down box the appropriate diagnosis type. Click on the <a href="#">[?]</a> for help text.	Mandatory Information
Level	Select from the drop-down box the appropriate diagnosis level. Click on the <a href="#">[?]</a> for help text.	Mandatory Information
Diagnosis	Enter the specific diagnosis name that has been provided by the medical professional who has assessed and provided the official diagnosis for the person we support.	Mandatory Information
Diagnosed by a qualified professional as having any disabilities	Select 'Yes' or 'No' if the diagnosis provided is linked with a disability.	Mandatory Information
Requires Management Plan	It is an expectation that all people we support with an official diagnosis would have a management plan. Select 'Yes' or 'No' depending on if a management plan available/required. If 'Yes' indicate where the management plan is located, if 'No' please provide context in the Notes section.	Mandatory Information
Notes	Provide notes regarding the absence of a management plan or any other relevant information to the diagnosis.	Mandatory Information
Clinical Diagnoses/ Disability/Mental Health	List any un-confirmed/pending diagnosis information. This section aims to hold information that is related to clinical diagnosis/disability/mental health, however, there may not be an official diagnosis. If there is no additional information to add, state 'See Diagnosis Information'.	Desirable Information
Allergies and Adverse Reactions	Select 'Yes' or 'No' depending on if the person we support has confirmed allergies or adverse reactions.	Mandatory Information
Allergies and Adverse Reactions Notes	If 'Yes', add relevant information for correct health management. List in dot points and indicate if the Care Team need to review additional information in other locations (TAR, Positive Behaviour Support Plan/Safety Plan). If 'No' state 'No present concerns'.	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Asthma	Select 'Yes' or 'No' depending on if the person we support experiences asthma.	Mandatory Information
Asthma Notes	If 'Yes', add relevant information for correct health management. List in dot points and indicate if the Care Team need to review additional information in other locations (TAR, Positive Behaviour Support Plan/Safety Plan). If 'No' state 'No present concerns'.	Mandatory Information
Diabetes	Select 'Yes' or 'No' depending on if the person we support has a diagnosis of diabetes.	Mandatory Information
Diabetes Notes	If 'Yes', add relevant information for correct health management. List in dot points and indicate if the Care Team need to review additional information in other locations (TAR, Positive Behaviour Support Plan /Safety Plan). If 'No' state 'No present concerns'.	Mandatory Information
EPI Pen	Select 'Yes' or 'No', depending on if the person we support has been prescribed the use of an EPI Pen.	Mandatory Information
EPI Pen Notes	If 'Yes', add relevant information for correct health management. List in dot points and indicate if the Care Team need to review additional information in other locations (TAR, Positive Behaviour Support Plan/Safety Plan). If 'No' state 'No present concerns'.	Mandatory Information
Medications Taken	Select 'Yes' or 'No' depending on if the person we support currently takes medication.	Mandatory Information
Medications Taken Notes	State 'Current medications listed in Medication Chart'.	Mandatory Information
Seizures	Select 'Yes' or 'No' depending on if the person we support experiences seizures.	Mandatory Information
Seizures Notes	If 'Yes', add relevant information for correct health management. List in dot points and indicate if the Care Team need to review additional information in other locations (TAR, Positive Behaviour Support Plan/Safety Plan). If 'No' state 'No present concerns'.	Mandatory Information
Other	Select 'Yes' or 'No' depending on if there are any additional <i>critical</i> medical information that has not been captured in this section.	Non-mandatory Information
Other Notes	If 'Yes', add details and relevant information for correct health management. List in dot points and indicate if the Care Team need to review additional information in other locations (TAR,	Non-mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	Positive Behaviour Support Plan/Safety Plan). If 'No' state 'No present concerns'.	

### About Me

CTARS Field Name	Type of information for Field	Information Category
Height (cm)	Enter the current height of the person we support. If height is unknown, leave blank, however this information should be entered as soon as possible. This information needs to be updated every six (6) months at minimum, or if the person we support has experienced a growth spurt. This information is used in several reports, including Benchmark and supports Missing Person Reports.	Mandatory Information
Weight (Kg)	Enter the current weight of the person we support. This should be updated every six (6) months at minimum, however, ideally updated every month or after health checks. This information is not critical or mandatory. If a person we support is unwilling or finds this information challenging to provide, do not enter.	Desirable Information
Eye Colour	Enter the person we support's eye colour. This information is used to support Missing Person Reports.	Mandatory Information
Hair Colour	Enter the person we support's natural hair colour (add in brackets if currently has dyed hair). This information only needs to be updated if the person we support makes noticeable changes to their hair colour. This information is used to support Missing Person Reports.	Mandatory Information
Skin Colour	Enter the person we support's skin colour. This information is used to support Missing Person Reports.	Mandatory Information
Identifying Features	Add information regarding any identifying features that the person we support has, this may be noticeable scars, piercings. Update as needed. If no additional identifying features need to be added, please state 'Not applicable at this time'.	Desirable Information

### My Contact Details

CTARS Field Name	Type of information for Field	Information Category
Address	Enter the person we support's current approved address. This will often be the program house address or located on the Authority to Care (ATC).	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Mailing Address	Enter the person we support's postal address. If they have no additional postal address (such as their mail is directed to a guardian or Child Safety Officer (CSO) enter the MC Nudgee Office. Christina White Building, 131 Queens Road, Nudgee, 4014 QLD.	Mandatory Information
Contact Number	Enter the MC Nudgee Office number: (07) 3267 9000.	Mandatory Information
Email	Enter the person we support's personal email, if unknown/does not have one, leave blank as only correct email addresses can be entered into this field.	Desirable Information
Mobile Number	Enter the person we support's personal mobile number. If unknown/does not have one, leave blank as only complete phone numbers can be entered into this field.	Desirable Information
Fax Number	Enter the MC Nudgee Office fax number: (07) 3267 0569.	Mandatory Information

### Culture, Language, Religion

CTARS Field Name	Type of information for Field	Information Category
Country of Birth	Please select the appropriate box depending on the person we support's country of birth. If selecting 'Other (Specify)', enter their country of birth in the field provided.	Mandatory Information
Indigenous Status	Select the appropriate box to indicate the person we support's indigenous status. <b>Note: Required information for Quarterly Reporting.</b>	Mandatory Information
Ethnicity	If known, please enter the person we support's ethnic background and the related parent. This can include their community/country/mob location. This section is free text.	Desirable Information
Languages	Select from the drop-down list the languages that the person we support speaks.	Mandatory Information
Dialect	If known, please enter the dialect of the languages the person we support speaks. This is a free text section.	Desirable Information
Interpreter Required	Select 'Yes' or 'No' depending on if the person we support requires an interpreter.	Desirable Information
Interpreter Required Notes	If 'Yes' add relevant information, such as interpreter services or when an interpreter is needed. If 'No' state 'No support required.'	Desirable Information

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CTARS Field Name	Type of information for Field	Information Category
Religion	If known, enter the religion that the person we support associates with. If this is unknown, state 'None identified'.	Mandatory Information
Religious and Cultural Practices	Select 'Yes' or 'No', depending on if the person we support engages in religious and cultural practices.	Mandatory Information
Religious and Cultural Practices Notes	If 'Yes', please briefly outline the religious and cultural practices and state where the Care Team can access additional information regarding the support required. This includes a statement of "Please see Cultural Support Plan for details on religious and cultural practices". If 'No', state 'None identified'	Mandatory Information

### Education

CTARS Field Name	Type of information for Field	Information Category
Add Education	Click on the <a href="#">Add Education</a> button to add education school/institution information. Complete all sections before saving.	Mandatory Information
School/Institution	Enter the name of the school or institution that the person we support is currently attending or has attended in the past.	Mandatory Information
Type	Select from the drop-down list the most appropriate categories for the above stated school.	Mandatory Information
Description	Provide relevant details regarding the person we support's engagement, course details and outcomes. This may include details of the days attended, course topics, reason for leaving (graduation/exited).	Mandatory Information
Start Date	Enter the date that the person we support started at the school/institution.	Mandatory Information
End Date	Enter the date the person we support completed/ finished attending the institution. If the person we support is currently attending and has not finished, leave this blank.	Mandatory Information

### Legal Orders and Authorities

CTARS Field Name	Type of information for Field	Information Category
Add Legal Orders	Click on the <a href="#">Add Legal Orders</a> button to add information. Complete all sections before saving.	Mandatory Information
Order Type	Select from the drop down-list the most appropriate order type. "Guardianship Order" is	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	the order type that will match people we support in RCaTS for whom the Department have Guardianship. For people we support who are subject to Custody Orders, select "Court Order". This information can be found on their ATC.	
Order Summary	State/listed order details, such as full specific QLD Child Safety order names (e.g., Long-Term Guardianship – Chief Executive, Short Term Custody Order).	Mandatory Information
Order Details	Add any additional contextual information regarding the legal order.	Desirable Information
Start Date	Enter the order start date as per QLD Child Safety documentation.	Mandatory Information
End Date	Enter the order end date as per QLD Child Safety documentation, if not listed leave blank.	Mandatory Information
Amendment to Order	Add details of any changes or amendments that have been made to the Legal Orders.	Desirable Information
Amendment Date	First Amendment Date, if required.	Desirable Information
Notes	Add any additional amendment dates/information, as required.	Non-mandatory Information

### Cards, Concessions, and ID

CTARS Field Name	Type of information for Field	Information Category
CTARS Client ID	This number is auto filled within the CTARS system. This is the unique number that CTARS assigns every person we support entered into the system.	Mandatory Information
External ID	Enter the person we support's ICMS QLD Child Safety number. This number is found in the person we support's referral information.	Mandatory Information
NDIS Client ID	If the person we support has an NDIS Plan, enter their Client ID number. If the person we support does not have an NDIS Plan, leave blank.	Mandatory Information
CoS ID	Not relevant for any people we support, enter 'N/A'.	Non-mandatory Information
Centrelink CRN	Enter the person we support's Centrelink Client Reference Number (CRN). If they do not have a CRN, leave blank until the number can be entered.	Mandatory Information
Companion Card Number	Linked with any Companion supports, mostly linked with NDIS, however, can include Companion travel supports. Enter any relevant Companion Card Numbers.	Desirable Information

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CTARS Field Name	Type of information for Field	Information Category
DSS Case ID Number	Not relevant for any people we support, enter 'N/A'.	Non-mandatory Information
DSS Client ID Number	Not relevant for any people we support, enter 'N/A'.	Non-mandatory Information
DVA Card Type	If relevant, select the Department Veteran Affairs (DVA) card type and enter card number and expiry date. If not relevant, enter 'N/A'.	Desirable Information
Health Care Card Number	Additional Medicare Healthcare card, such as Foster Care Health Card, Low Income Healthcare Card. All people we support should have this card. Enter the card number and expiry date.	Mandatory Information
Individual Healthcare Identifier (IHI)	This is a unique 16-digit number the My Health Record system uses to identify and individual. Enter the number. If the number is unknown, leave blank until it can be entered.	Mandatory Information
Child Story Identifier from CS	Not relevant for any people we support, enter 'N/A'.	Non-mandatory Information
Library Card Number	Enter the person we support's personal library card number and expiry date. Also list what Library the card is linked to. If the person we support does not have a library card, state 'no current card'.	Desirable Information
Medicare Card Number	Enter the person we support's personal Medicare Card Number and expiry date. This is critical information and must be entered as soon as possible.	Mandatory Information
Pension Number	Enter the Pension Number and expiry date. May not be relevant for MC RCaTS people we support. If this is not relevant for the person we support, enter 'N/A' and leave the expiry date blank.	Non-mandatory Information
Private Health Insurance Card Number	Enter the number and expiry date for the person we support's private health insurance. This may not be relevant for some people we support. Ensure the name of the Private Health Insurance Provider is added in the separate box. If the person we support does not have private health insurance, state 'N/A' in both provider and card number fields.	Desirable Information
Proof of Age Card	Enter the person we support's QLD Proof of Age Card number and expiry date. Not all people we support will have this card, if they don't, state 'no current card'.	Desirable Information
Public Guardian Client Number	This is generated for adults, however, may be generated in preparation for transition to adulthood. Add this number if the person we	Desirable Information

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CTARS Field Name	Type of information for Field	Information Category
	support has one, if they don't, state 'no current number'.	
Public Trust Client Number	This is generated for adults, however, may be generated in preparation for transition to adulthood. Add this number if the person we support has one, if they don't, state 'no current number'.	Desirable Information
Seniors Card Number	Not relevant for any people we support. Enter 'N/A' and leave expiry blank.	Non-mandatory Information
Tax File Number	Enter the person we support's Tax File Number. This is a critical number for all people we support. If the person we support does not have this number, leave blank as the field will only accept full Tax File Numbers.	Mandatory Information
Transport Card	Enter the card number. This includes any electronic transport cards, such as Go Card.	Desirable Information

### Assets and Possessions

CTARS Field Name	Type of information for Field	Information Category
Add Asset and Possession	Select the <a href="#">Add Asset and Possession</a> button to enter the person we support's personal items that they have purchased with their own money while in MC's care or entered MC's care in the possession of. This will support decision making around future purchases and support the reduction of people we support losing items while in MC care. Complete and save.	Mandatory Information
Asset Description	Enter a description of the item/s. This may be a list of grouped items (such as clothing and shoes) or a specific item (such as phone or photo album).	Mandatory Information
Asset Location	State where the item has been stored. This may be the person we support's bedroom, program office, MC office (specify which office and where) or returned to Child Safety (specify who received the items).	Mandatory Information
Replacement Value	Enter an approximate replacement cost of the item/s in the event they were broken. This does not indicate that MC will pay for the items if broken.	Mandatory Information
Receipt Available	Select 'Yes' or 'No'. If 'Yes', save receipt in corresponding file in Documents.	Mandatory Information

### External Client Links

CTARS Field Name	Type of information for Field	Information Category
Add Hyperlink	Select the <a href="#">Add Hyperlink</a> button and complete all fields before saving. This section holds two (2) types of information. The first is <i>Mandatory</i> , this is the list of people/stakeholders that MC is required/requested to email any Incident Report PDF's to. The mailing list is entered into this section so anyone sending Incident Reports is aware of the correct recipients. The second is <i>Desirable Information</i> only and is relating to informational links for the Care Team working with the person we support, this may be training refresher videos or facts pages.	Mandatory/Desirable Information
Label	Provide a name to support the Care Team identify what the link is connected to.  IR Distribution Note: Label IR email list as <i>Incident Report Mailing List</i> .	Mandatory Information
Description	Provide details of the type of information and purpose of viewing.  IR Distribution Note: Use this section to list all emails for people/stakeholders who must receive the Incident Report PDF. Separate each email address with a (;) for easy copying.	Mandatory Information
Hyperlink	Insert the hyperlink to the webpage, video, etc.  IR Distribution Note: This section is Mandatory, however, is not required for the Incident Report Mailing List information, enter N/A.	Mandatory Information

### Contacts/Hierarchy

The 'Contacts/Hierarchy' section holds information regarding important contact people and services for the person we support and the internal MC hierarchy linking them to the programs they are connected to.

### Contacts

CTARS Field Name	Type of information for Field	Information Category
Add Contact	Select the <a href="#">Add Contact</a> button and complete all fields before saving. Add all relevant stakeholders, family, peers, and services providers that support the person we support.  <i>Note: Aspects of this part of the Profile information pull into to the Benchmark Report.</i>	Mandatory Information
Title	Enter the appropriate personal title for the contact person (Dr, Mr, Mrs, Miss, Ms, etc.).	Desirable Information

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CTARS Field Name	Type of information for Field	Information Category
Contact Name/ Organisation	Enter the name of the contact person (such as the CSO's name) or the organisation that is providing a service (such as Headspace).	Mandatory Information
Date of Birth	If known, add the contact's date of birth. This information is more important for family members.	Non-mandatory Information
Contact Type	Select the most appropriate role that the contact person holds with the person we support. Note: Below are critical roles to add and have key Contact Types names within CTARS: <ul style="list-style-type: none"> <li>• Child Safety Team Leader = Case Manager</li> <li>• Child Safety Officer = Case Worker</li> <li>• MC CTL = Internal Case Worker</li> </ul>	Mandatory Information
Relationship to Client	Select the appropriate relationship title from the drop-down list. <i>Note: If not a family relationship, select either Guardian (if specified on Legal Order) or Other (provide detail of relationship, such as Custodian or MC Representative).</i>	Mandatory Information
Relationship Status	Select the most appropriate option from the drop-down list. This information will support Care Team members understanding relationship dynamics between family members.	Mandatory Information
Emergency Contact	Select the type of emergency contact from the drop-down list that the contact person should receive in the case of an emergency. If they should not be contacted in the event of an emergency, leave blank. Ensure that Child Safety representatives are listed as Primary emergency contacts as this information is then pulled through to other forms and reports.	Mandatory Information
Home Number	The contact person's home number if accessible/appropriate.	Desirable Information
Mobile Number	The contact person's mobile number if accessible/appropriate.	Mandatory Information
Work Number	The contact person's work number if accessible/appropriate.	Desirable Information
Fax Number	The contact person's fax number if accessible/appropriate.	Desirable Information
Email	The contact person's email address if accessible/appropriate.	Desirable Information
Address	The contact person's address if accessible/appropriate. This may be a work or home address depending on the contact person.	Desirable Information

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CTARS Field Name	Type of information for Field	Information Category
Indigenous Status	The contact person's indigenous status. If unknown, select 'Not Stated'.	Desirable Information
Indigenous Nation/ Country	The contact person's indigenous nation/country, if known or applicable.	Desirable Information
Additional Cultural Requirements/ Details	Any additional information regarding cultural requirements or details that would support the Care Team to positively interact and engage with this person.	Desirable Information
Next of Kin/ Guardian	If the contact person is a next of kin/guardian for the person we support, select the appropriate box. If the contact person is neither, leave blank.	Mandatory Information
Effective Date From	This date relates to the length of the Guardianship Order if the contact person is the guardian for the person we support.	Desirable Information
Effective Date To	This date relates to the length of the Guardianship Order if the contact person is the guardian for the person we support.	Desirable Information
Orders	Select 'Yes' or 'No' in any of the following areas the contact person has legal orders in relation to the person we support: <ul style="list-style-type: none"> <li>Apprehended Violence Order</li> <li>Parenting Order</li> </ul> Ensure to add details of the orders in the text field that appears.	Mandatory Information
Assistance Filling Out Forms	Does the contact person need assistance filling out forms? This relates to ensuring that when MC is interacting with the contact person, the correct supports are offered.	Desirable Information
Language Spoken	Select 'Yes' and add the primary language spoken to the person we support by the contact person.	Desirable Information
Interpreter Required	Does the contact person require an interpreter? This relates to ensuring that when MC is interacting with the contact person, the correct supports are offered.	Desirable Information
Power of Attorney	Does the contact person have Power of Attorney for the person we support? If 'Yes', provide details in the text field that appears.	Mandatory Information

### Assigned Staff

CTARS Field Name	Type of information for Field	Information Category
Selected Staff	This field is currently not required to be completed.	Not required at this time

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CTARS Field Name	Type of information for Field	Information Category
Selected Key Workers	In this section, enter the name of the Caseworker, CTL that is associated with the person we support. This is information that is particularly key for Transitional Services and reporting of caseloads. <i>Note: Required information for Quarterly Reporting.</i>	Mandatory Information

### Hierarchy

CTARS Field Name	Type of information for Field	Information Category
Add Hierarchy	Select the <a href="#">Add Hierarchy</a> button to add the person we support's unit/program location. Complete all fields and save. Some people we support may have more than one (1) hierarchy. For example, they would have a hierarchy for the unit that they live in, and a hierarchy for accessing SILP Outreach. <i>Note: Required information for Quarterly Reporting.</i>	Mandatory Information
Please select a State	Select the relevant State (e.g., QLD).	Mandatory Information
Please select a Region	Select the relevant region for the person we support, this may be their geographic region (e.g., South East) or the Program Overview region (e.g. Transitional Services).	Mandatory Information
Please select a Unit	Select the unit/program that the person we support is living in/supported by.	Mandatory Information

### Placement/Programs

The 'Placement/Programs' section holds information relating to the current and historical placement provided to the person we support.

### Living Arrangements/Placement History

CTARS Field Name	Type of information for Field	Information Category
Add Living Arrangement	Select the <a href="#">Add Living Arrangement</a> button to add current and historical living arrangements. This should include the current MC placement, and three (3) past placements (if the information is available). Ensure the entry date for the current MC placement is included as this data will be used for reporting. Ensure to add the placement exit date to the corresponding MC placement when the person we support exits prior to deactivating the profile, as this data will be used for reporting. Complete all fields and save.	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	<i>Note: Required information for Quarterly Reporting (?)</i>	
Type of Living Arrangement/ Placement	Select the most appropriate categories for the type of living/placement arrangement. This information outlines the level of engagement/support the person we support requires from MC. <i>Note: Required information for Quarterly Reporting</i>	Mandatory Information
Agency	Enter name of the agency/organisation that is associated with the placement.	Mandatory Information
Name	Enter the program name of the placement (e.g., Petrie). If the program name is unknown, enter the Agency name in this section.	Mandatory Information
Primary Carer	Enter the name of the primary carer for the person we support for the placement. This is generally for foster and kinship care arrangements. For residential or shared living placements where there is no clearly identified primary carer, leave blank.	Desirable Information
Commencement Date	Enter the date when the placement started. <i>Note: Required information for Quarterly Reporting.</i>	Mandatory Information
Reason for Entering Placement	Select the drop-down options that best suits the person we support's situation. If none are suitable, select 'Other'.	Mandatory Information
Entering into Voluntary Care	Voluntary Care is when the client makes their own choice to enter care, and the decision has been supported by governing agency. This mostly occurs with adults, however, some people we support with make this choice.	Mandatory Information
Entering into Voluntary Care Notes	Add notes regarding the details of the person we support's choice of entering into care. For example, this may be "X was removed from family due to Departmental Orders" or "X made a voluntary choice to enter into the program".	Mandatory Information
Is the Person Self-Placed?	Self-Placed is when the person we support makes their own choice around leaving the agency placement and living with other people. This would be relevant for past placements when a person we support has 'self-placed' with family/friends for a period of time.	Mandatory Information
Is the Person Self-Placed Notes	If 'Yes', add notes regarding any details of the person we support's choice to self-place. If 'No', state 'N/A'.	Mandatory Information
Legal Status/ Placement Status	Select the most appropriate option from the drop-down list. Majority of the people we support in MC	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	care would be “Guardianship order”, “Court Order” or “Temporary Care Order”.	
Purpose of Placement	Select from the drop-down list the overarching goal of the placement. This is a goal set by Child Safety regarding the permanency plan for the person we support. <i>Note: Required information for Quarterly Reporting.</i>	Mandatory Information
Services provided by Agency to Client prior to entering care	Select any service that the person we support was provided with before entering care. This would include any Departmental Interventions. Multiple services can be selected.	Desirable Information
Siblings/Family in Same Placement	Select the best description of the current situation of the person we support’s family/siblings in care.	Mandatory Information
Placement is Culturally Compatible	Select ‘Yes’ or ‘No’ regarding if the placement is culturally compatible for the person we support. In past placements, this may have been part of the reason for the placement backdown/closure.	Mandatory Information
Placement is Culturally Compatible Notes	If ‘No’, add notes of why the placement was not culturally compatible. If ‘Yes’ state “Placement meets cultural needs”.	Mandatory Information
Aboriginal and Torres Strait Islander Placement Principles Applied	Select ‘Yes’ or ‘No’, regarding if the Aboriginal and Torres Strait Islander Placement Principles are relevant to the person we support and if they have been applied. These principles can be found at <a href="#">Aboriginal and Torres Strait Islander Placement Principles</a> .	Mandatory Information
Aboriginal and Torres Strait Islander Placement Principles Applied Notes	If ‘No’, add notes of why the placement principles have not been applied. If ‘Yes’, state “Placement Principles have been met”.	Mandatory Information
Exit Date	Add the exit date of the historical placements. For current placement entries this remains empty. Ensure to add the placement exit date to the corresponding MC placement when the person we support exits prior to deactivating the profile. <i>Note: Required information for Quarterly Reporting.</i>	Mandatory Information
Placement Exit Notes	Add any relevant details regarding the person we support’s exit from a placement. This would include the presence of a transition plan, the length of notice they had, their emotional distress during the exit. For current placements, this remains empty.	Mandatory Information
Reason for Exiting the Placement	Select the most appropriate reason for the placement closure. For current placements, this	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	remains empty. For unplanned moves/exits, select 'Placement Breakdown'. <i>Note: Required information for Quarterly Reporting.</i>	
Is the person leaving care period with your agency?	Select 'Yes' or 'No' depending on the current plan for the person we support. This is directly related to the age of the person we support and if they will be transitioning out of care from this program.	Mandatory Information
Is the person leaving the care period with your agency? Notes	Enter contextual information regarding the 'Yes' or 'No' answer above.	Mandatory Information
Person referred to any other After Care Services?	Select 'Yes' or 'No' depending on the current plan for the person we support. This is directly related to the age of the person we support and what supports they will be provided after leaving care.	Mandatory Information
Person referred to any other After Care Services? Notes	Enter contextual information regarding the 'Yes' or 'No' answer above.	Mandatory Information
Documentation completed to support move? (Transitioning Care Plan)	Select 'Yes' or 'No' depending on the current plan for the person we support. This is referring to Department's Transition to Adulthood Plan.	Mandatory Information
Documentation Completed to support move? (Transitioning Care Plan) Notes	Enter contextual information regarding the 'Yes' or 'No' answer above.	Mandatory Information

### Programs

CTARS Field Name	Type of information for Field	Information Category
Client Program	Select from the drop-down list, RCaTS programs will be Out-of-home Care (OOHC) Residential.	Mandatory Information
Program	Select all relevant programs that the person we support will be engaged in. For RCaTS, this will always include 'Out of Home Care – Residential' and may include 'Community Access/Participation and/or Day Program'. For Transition Services, select 'Other' and specific program type.	Mandatory Information
Notes	Enter details to link the programs selected with MC programs.	Mandatory Information

### Personal Care

This section provides information for the Care Team member regarding the person we support's capacities and needs to manage their personal care. This section also holds the Safety Planning information regarding risk and crisis management.

#### Bathing and Grooming

CTARS Field Name	Type of information for Field	Information Category
Assistance	Select 'Yes' or 'No' depending on if the people we support requires physical support to complete the following tasks: <ul style="list-style-type: none"> <li>Clean teeth</li> <li>Fill a bath or run a shower</li> <li>Shaving</li> <li>Washing hair</li> <li>Washing hands</li> </ul>	Mandatory Information
Assistance Notes	If 'Yes', provide information under the following headings: <ul style="list-style-type: none"> <li>Level of Risk (Low, Medium, High)</li> <li>Proactive Support Strategies</li> <li>Crisis Support Strategies</li> </ul> If no support is required, state 'No support required'.	Mandatory Information
Bath or Shower Preference	Select the person we support's preference of either a bath or shower. Sponge bath option is linked with disability clients who are unable to use a bath or shower and have a carer sponge bath them instead.	Mandatory Information
Dress by Themselves	Select 'Yes' or 'No' depending on whether the person we support requires physical support to dress themselves.	Mandatory Information
Dress by Themselves Notes	If 'Yes', enter details on how the Care Team are to support the person we support with the task. If 'No' comment if the person we support requires prompting or hurdle help to complete the tasks. If no support is required, state "Can complete independently".	Mandatory Information
Hot Water Awareness (Assess Risk)	Select 'Yes' or 'No' depending on the person we support's ability to safely engage with hot water.	Mandatory Information
Hot Water Awareness (Assess Risk) Notes	If 'Yes', provide information under the following headings: <ul style="list-style-type: none"> <li>Level of Risk (Low, Medium, High)</li> <li>Proactive Support Strategies</li> <li>Crisis Support Strategies</li> </ul>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	If no support is required, state 'No support required'.	
Manage Buttons, Zippers, etc. by self	Select 'Yes' or 'No' depending on the person we support's ability to use buttons and zippers on clothing.	Mandatory Information
Manage Buttons, Zippers, etc. by self Notes	If 'Yes', enter details on how the Care Team are to support the person we support with the task. If 'No', comment if the person we support requires prompting or hurdle help to complete the tasks. If no support is required, state "Can complete independently".	Mandatory Information
Normal Bathing Time	Add an approximate normal bathing time. This can be set to program design normal expectations unless these are key timings for the person we support.	Mandatory Information
Special Bath Oil, Shampoo, Soap?	Select 'Yes' or 'No' depending on the person we support's requirement for special bath oils, shampoo, or soap. This may be related to skin conditions or hygiene preference.	Mandatory Information
Special Bath Oil, Shampoo, Soap? Notes	If 'Yes', enter details on what special actions/tools the Care Team need to take to support the person we support. If 'No', comment if the person we support requires prompting or hurdle help to complete the tasks.	Mandatory Information
Supervision Required Whilst Bathing?	Select 'Yes' or 'No' depending on if the person we support requires supervision when bathing.	Mandatory Information
Supervision Required Whilst Bathing? Notes	If 'Yes', enter details on how the Care Team are to support the person we support with the task. If 'No', comment if the person we support requires prompting or hurdle help to complete the tasks or specific supports to best manage their hygiene.	Mandatory Information

### Bedtime Routine

CTARS Field Name	Type of information for Field	Information Category
Continence Aids to Bed	Select 'Yes' or 'No' depending on if the person we support requires the use of continence aids at bedtime. Continence aids are items such as pads and nappies to prevent bedwetting.	Mandatory Information
Continence Aids to Bed Notes	If 'Yes', provide information under the following headings: <ul style="list-style-type: none"> <li>Level of Risk (Low, Medium, High)</li> <li>Proactive Support Strategies</li> <li>Crisis Support Strategies</li> </ul>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	If no support is required, state 'No support required'.	
Indicates when wanting to go to bed	Select 'Yes' or 'No' depending on if the person we support can identify that they are tired and want to go to bed.	Mandatory Information
Indicates when wanting to go to bed Notes	If 'Yes', enter details on how the Care Team are to support the person we support with the task. If 'No', comment if the person we support requires prompting or hurdle help to complete the tasks or specific supports to best manage bedtime. If no support is required, state "Support not required".	Mandatory Information
Problems sleeping away from normal residence	Select 'Yes' or 'No' depending on if the person we support has any problem sleeping away from the normal residence.	Mandatory Information
Problems sleeping away from normal residence Notes	If 'Yes', enter details on how the Care Team are to support the person we support with the task. If 'No', comment if the person we support requires prompting or hurdle help to complete the tasks or specific supports to best manage a situation when sleeping away from normal residence. If no support is required, state "Support not required".	Mandatory Information
Sleeps with Bedroom Door Closed	Select 'Yes' or 'No' depending on if the person we support sleeps with the bedroom door closed. (Note- bedroom door should be closed due to door alarms)	Mandatory Information
Sleeps with Bedroom Door Closed Notes	If 'Yes' or 'No', enter details how the Care Team are to support the person we support with the task. If no support is required state "Support not required".	Mandatory Information
Sleeps with Light On	Select 'Yes' or 'No' depending if the person we support sleeps with a light on.	Mandatory Information
Sleeps with Light On Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task.	Mandatory Information
Sleeps in a Single Room	Select 'Yes' or 'No' depending on if the person we support sleeps in their own bedroom.	Mandatory Information
Sleeps in a Single Room Notes	Add the following to the notes section "All people we support in the program have their own single bedrooms". Enter details on how the Care Team are to support the person we support with the task. If no support is required, state "Support not required".	Mandatory Information

CTARS Field Name	Type of information for Field	Information Category
Special Sleeping Needs	Select 'Yes' or 'No' depending on if the person we support requires any special sleeping supports (such as weighted blanket, more pillows).	Mandatory Information
Special Sleeping Needs Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task. If no support is required, state "Support not required".	Mandatory Information
Repositioned during night	Select 'Yes' or 'No' depending on if the person we support requires physical re-positioning during the night. This is generally related to issues with physical disabilities or breathing during sleep.	Mandatory Information
Repositioned during night Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task. If no support is required, state "Support not required".	Mandatory Information
Sleep through the night	Select 'Yes' or 'No' depending on if the person we support is able to sleep through the night without waking. This is referring to consistent presentations of being unable to sleep through the night.	Mandatory Information
Sleep through the night Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task. If no support is required, state "Support not required".	Mandatory Information
Usual Bedtime Routine	Select 'Yes' or 'No' depending on if the person we support has a set bedtime routine. All RCaTS programs should have clear bedtime routines.	Mandatory Information
Usual Bedtime Routine Notes	State "Refer to the Positive Behaviour Support Plan and current Activity Planner for Individual Person We Support Routines". This is due to the possibility that routines change and not wanting to enter commentary that may quickly become out of date or untrue to the person we support's situation.	Mandatory Information
Other (specify)	Select 'Yes' or 'No' depending on if the person we support has any additional bedtime routine information. This may include the need to support the person we support with checking that the house is locked due to safety anxiety at night. If needed, add details to the notes section. If not, leave the notes section blank.	Mandatory Information

### Behaviour Support

The Behaviour Support Risk Plan section of CTARS is not being used; this information is captured in the *FS FORM RCaTS Positive Behaviour Support Plan*. Refer to *FS PROC RCaTS Positive Behaviour Support* for further information.

### Communication

CTARS Field Name	Type of information for Field	Information Category
Communication Method	Select the most common methods of communication that the person we support uses (this may include more than one).	Mandatory Information
Communication Method Notes	Provide contextual detail regarding the person we support's listed communication method. This may be that they are more likely to use 'Vocalisation' or 'Gestures' when distressed, while will use 'Speech' when at base line.	Mandatory Information
Communication Plan Available?	This is referencing a person we support's specific proactive strategy regarding unique ways for the Care Team to communicate with the person we support. This is generally relevant for people we support with communication disabilities or challenges and may not be relevant for all people we support.	Mandatory Information
Communication Plan Available? Notes	If 'Yes', state where the communication plan is accessible from. If 'No', indicate details of why there is not plan. For example, "No Specific Communication Plan is required to support this person we support, Care Team members are to follow TCI strategies regarding positive communication".	Mandatory Information
Happiness	Provide a brief description of how the person we support presents this emotion. This section is to provide the Care Team with information regarding how the person we support presents. This is not the place for strategies or intervention. Present this information in dot point form.	Mandatory Information
Anger	Provide a brief description of how the person we support presents this emotion. This section is to provide the Care Team with information regarding how the person we support presents. This is not the place for strategies or intervention. Present this information in dot point form.	Mandatory Information
Hunger	Provide a brief description of how the person we support presents this feeling. This section is to provide the Care Team with information regarding how the person we support presents. This is not	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	the place for strategies or intervention. Present this information in dot point form.	
Pain	Provide a brief description of how the person we support presents this feeling. This section is to provide the Care Team with information regarding how the person we support presents. This is not the place for strategies or intervention. Present this information in dot point form.	Mandatory Information
Reading	Provide a brief description on the person we support's ability to read. This may include any actions/behaviour they display when finding reading challenging. This section is to provide the Care Team with information regarding how the person we support presents. This is not the place for strategies or intervention. Present this information in dot point form.	Mandatory Information
Sadness	Provide a brief description of how the person we support presents this feeling. This section is to provide the Care Team with information regarding how the person we support presents. This is not the place for strategies or intervention. Present this information in dot point form.	Mandatory Information
Staying Away from Home	Provide a brief description of how the person we support presents when staying away from home over night (such as a sleepover). This section is to provide the Care Team with information regarding how the person we support presents. This is not the place for strategies or intervention. Present this information in dot point form.	Mandatory Information
Telephone Usage	Provide a brief description on how the person we support requests the use of a telephone. This section is to provide the Care Team with information regarding how the person we support presents. This is not the place for strategies or intervention. Present this information in dot point form.	Mandatory Information
Thirst	Provide a brief description of how the person we support presents this feeling. This section is to provide the Care Team with information regarding how the person we support presents. This is not the place for strategies or intervention. Present this information in dot point form.	Mandatory Information
Toileting	Provide a brief description of how the person we support presents the need to use the toilet. This section is to provide the Care Team with information regarding how the person we support	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	presents. This is not the place for strategies or intervention. Present this information in dot point form.	
Writing	Provide a brief description on the person we support's ability to write. This may include any actions/behaviour they display when finding reading challenging. This section is to provide the Care Team with information regarding how the person we support presents. This is not the place for strategies or intervention. Present this information in dot point form.	Mandatory Information

### Community Access

CTARS Field Name	Type of information for Field	Information Category
Likes	List the activities that the person we support has expressed positive interest in engaging in when accessing community.	Mandatory Information
Dislikes	List the activities/situations that the person we support has expressed a concern or dislike in engaging in when accessing community.	Mandatory Information
Additional Resources or Supports Required?	All people we support require support and resources when accessing the community. This section is referring to resources and supports that must be in place due to a high level of risk for the person we support when in community. These types of supports may be 'line of sight' supervision, physical interventions when in community or proactive removal of the person we support in select community environments.	Mandatory Information
Additional Resources or Supports Required? Notes	If 'No', state 'Care Team members are to provide community access support in line with the relevant Mercy Advanced Practice (MAP) and MC training of TCI'. If 'Yes', ensure formation under the following headings, <ul style="list-style-type: none"> <li>Level of Risk (Low, Medium, High)</li> <li>Brief Description of Behaviour/Risk</li> <li>Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> <li>Crisis Support Strategies (Strategies/actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Attend School/Vocation?	Select 'Yes' or 'No' depending on if the person we support is engaged/enrolled in school or a vocational program.	Mandatory Information
Attend School/Vocation? Notes	If 'Yes', provide commentary on the type of support the person we support needs to access their school/vocation program (such as transported by carer/bus/walk, must be signed in, self-managed). If 'No', state 'Currently not engaged in any school/vocation program'.	Mandatory Information
Fears or Phobias?	Select 'Yes' or 'No' depending on if the person we support has expressed any clear fears and phobias relating to community access.	Mandatory Information
Fears or Phobias? Notes	If 'Yes', list the fears or phobias the person we support has expressed. If 'No', state 'No current presenting fears or phobias'.	Mandatory Information
No Participation due to Medical Reason?	Select 'Yes' or 'No' depending on if the person we support is unable to engage in certain types of community access due to medical reason.	Mandatory Information
No Participation due to Medical Reason? Notes	If 'Yes', list the community access activities that the person we support is unable to participate in due to medical reasons. Indicate where additional information can be found if needed. If 'No', state 'No present concerns'.	Mandatory Information
Public Transport with Support Staff?	Select 'Yes' or 'No' depending on if the person we support requires RCW support when catching public transport. This is based on a risk assessment of the person we support's safety in community and use of public transport.	Mandatory Information
Public Transport with Support Staff? Notes	<p>If 'Yes', ensure formation under the following headings,</p> <ul style="list-style-type: none"> <li>• Level of Risk (Low, Medium, High)</li> <li>• Brief Description of Behaviour/Risk</li> <li>• Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> <li>• Crisis Support Strategies (Strategies/actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p> <p>If 'No', outline the current level of risk and the current capacity the person we support is</p>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	displaying to access public transport (such as can catch school bus if they are met at the bus stop).	
Preferred Seating Requirements	All people we support traveling in a MC vehicle must comply with national safety rules such as use of booster seats for under seven (7) years old. MC holds the general expectation that all people we support sit in the back seat when traveling. This may be altered depending on the person we support's age and capacity to allow them to sit in the front seat. Select 'Yes' or 'No' depending on if the person we support requires unique seating arrangements when travelling (e.g., requires a Care Team member to sit next to them in the back seat).	Mandatory Information
Preferred Seating Requirements Notes	If 'Yes', list the current unique strategies that are in place. If 'No' state briefly outline the current seating arrangements in the person we support's program (such as 'All people we support must sit in the back seat when traveling in the car. There is a rotation agreement regarding who is able to sit in the front seat')	Mandatory Information
Recommended Maximum Travel Time	Select 'Yes' or 'No' depending on if the person we support finds extended travel times challenging and requires their travel times to be limited.	Mandatory Information
Recommended Maximum Travel Time Notes	If 'Yes', outline the recommended maximum length of time the person we support can travel for without causing distress. Indicate that the Care Team should refer to the Activity Planner regarding planned travel and break periods. If 'No', state 'No present concerns'.	Mandatory Information
Required Activity whilst Travelling	Select 'Yes' or 'No' depending on if the person we support is best supported by having planned activities/ task/items whilst traveling.	Mandatory Information
Required Activity whilst Travelling Notes	If 'Yes', list the activities/task/items that the person we support requires to be best supported while traveling. If 'No', state 'Is able to manage travel well, is best supported by general conversation and positive interactions from the Care Team'.	Mandatory Information
Road Safety	Select 'Yes' or 'No' depending on if the person we support is able to safely navigate being near roads and traffic, getting in and out of cars near the road and crossing roads.	Mandatory Information
Road Safety Notes	If 'Yes', state 'No present concerns'. If 'No', ensure formation under the following headings, <ul style="list-style-type: none"> <li>Level of Risk (Low, Medium, High)</li> </ul>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	<ul style="list-style-type: none"> <li>Brief Description of Behaviour/Risk</li> <li>Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> <li>Crisis Support Strategies (Strategies/ actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p>	
Small Groups with Support Staff	Select 'Yes' or 'No' depending on if the person we support requires support from the Care Team to safely manage interacting with small groups of people in the community.	Mandatory Information
Small Groups with Support Staff Notes	<p>If 'Yes', ensure formation under the following headings,</p> <ul style="list-style-type: none"> <li>Level of Risk (Low, Medium, High)</li> <li>Brief Description of Behaviour/Risk</li> <li>Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> <li>Crisis Support Strategies (Strategies/ actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p>	Mandatory Information
Travel Sickness	Select 'Yes' or 'No' depending on if the person we support experiences travel sickness.	Mandatory Information
Travel Sickness Notes	If 'Yes', outline presentation when experiencing travel sickness and current supports that are provided to the person we support to reduce the effects of travel sickness. If 'No', state 'No present concern'.	Mandatory Information
Pocket Money on Outings	Selects 'Yes' or 'No' depending on if the person we support is able to spend their pocket money during outings.	Mandatory Information
Pocket Money on Outings Notes	If 'Yes', outline if the person we support has pre-planned outings to spend pocket money or if they are able to spend money ad hoc during the week. If 'No', indicate when and how the person we support is able to engage in pocket money spending.	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Remains Seated whilst Travelling	Selects 'Yes' or 'No' depending on if the person we support remains seated during most of all car transport.	Mandatory Information
Remains Seated whilst Travelling Notes	<p>If 'Yes', ensure formation under the following headings,</p> <ul style="list-style-type: none"> <li>• Level of Risk (Low, Medium, High)</li> <li>• Brief Description of Behaviour/Risk</li> <li>• Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> <li>• Crisis Support Strategies (Strategies/ actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p>	Mandatory Information
Removes Seatbelt whilst Travelling	Select 'Yes' or 'No' depending on if the person we support attempts to remove their seatbelt often during travel.	Mandatory Information
Removes Seatbelt whilst Travelling Notes	<p>If 'Yes', ensure formation under the following headings,</p> <ul style="list-style-type: none"> <li>• Level of Risk (Low, Medium, High)</li> <li>• Brief Description of Behaviour/Risk</li> <li>• Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> <li>• Crisis Support Strategies (Strategies/ actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p>	Mandatory Information
Swimming/Water Sport Incontinence	Select 'Yes' or 'No' depending on if the person we support requires supports (such as nappies) when swimming.	Mandatory Information
Swimming/Water Sport Incontinence Notes	<p>If 'Yes', ensure formation under the following headings,</p> <ul style="list-style-type: none"> <li>• Level of Risk (Low, Medium, High)</li> <li>• Brief Description of Behaviour/Risk</li> <li>• Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> </ul>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	<ul style="list-style-type: none"> <li>Crisis Support Strategies (Strategies/actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p>	
Swimming/Water Sport Independent/Support Required	Select 'Yes' or 'No' depending on if the person we support requires physical support/close supervision when around water due to risk of drowning.	Mandatory Information
Swimming/Water Sport Independent/Support Required Notes	<p>If 'Yes', ensure formation under the following headings,</p> <ul style="list-style-type: none"> <li>Level of Risk (Low, Medium, High)</li> <li>Brief Description of Behaviour/Risk</li> <li>Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> <li>Crisis Support Strategies (Strategies/actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p>	Mandatory Information
Swimming/Water Sports Participation	Select 'Yes' or 'No' depending on if the person we support is permitted to engage in swimming and/or water sports.	Mandatory Information
Swimming/Water Sports Participation Notes	<p>If 'Yes', ensure formation under the following headings,</p> <ul style="list-style-type: none"> <li>Level of Risk (Low, Medium, High)</li> <li>Brief Description of Behaviour/Risk</li> <li>Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> <li>Crisis Support Strategies (Strategies/actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p>	Mandatory Information

CTARS Field Name	Type of information for Field	Information Category
Swimming/Water Sports Specialised Equipment	Select 'Yes' or 'No' depending on if the person we support requires specialised equipment to engage in swimming/water sports.	Mandatory Information
Swimming/Water Sports Specialised Equipment Notes	If 'Yes', outline the level of risk (low/medium/high) and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information
Swimming/Water Sports Wheelchair Access	Select 'Yes' or 'No' depending on if the person we support requires wheelchair access to engage in swimming/water sports.	Mandatory Information
Swimming/Water Sports Wheelchair Access Notes	If 'Yes', outline the level of risk (low/medium/high) and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information
Wheelchair Access Required into Venue	Select 'Yes' or 'No' depending on if the person we support requires wheelchair access.	Mandatory Information
Wheelchair Access Required into Venue Notes	If 'Yes', outline the level of risk (low/medium/high) and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information

### Eating, Drinking and Mealtimes

CTARS Field Name	Type of information for Field	Information Category
Breakfast (usual time)	Enter the general mealtime for the program the person we support is living in. State in the notes section "Refer to Activity Planner and Individual Routines."	Mandatory Information
Morning Tea (usual time)	Enter the general mealtime for the program the person we support is living in. State in the notes section "Refer to Activity Planner and Individual Routines."	Mandatory Information
Lunch (usual time)	Enter the general mealtime for the program the person we support is living in. State in the notes section "Refer to Activity Planner and Individual Routines."	Mandatory Information
Afternoon Tea (usual time)	Enter the general mealtime for the program the person we support is living in. State in the notes section "Refer to Activity Planner and Individual Routines."	Mandatory Information
Dinner (usual time)	Enter the general mealtime for the program the person we support is living in. State in the notes section "Refer to Activity Planner and Individual Routines."	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Supper (usual time)	Enter the general mealtime for the program the person we support is living in. State in the notes section "Refer to Activity Planner and Individual Routines."	Mandatory Information
Dislikes – Food and Drink	Select 'Yes' or 'No' depending on if the person we support has <i>strong</i> food or drink dislikes.	Mandatory Information
Dislikes – Food and Drink Notes	If 'Yes', list the foods and drinks that the person we support has a <i>strong</i> dislike for. If 'No', state 'No present concerns'.	Mandatory Information
Likes – Food and Drink	Select 'Yes' or 'No' depending on if the person we support has <i>strong</i> food or drink likes.	Mandatory Information
Likes – Food and Drink Notes	If 'Yes', list the foods and drinks that the person we support has a <i>strong</i> like for. If 'No', state 'No present concerns'.	Mandatory Information
Assistance with Eating or Drinking	Select 'Yes' or 'No' if the person we support requires physical assistance/close supervision when eating and/or drinking.	Mandatory Information
Assistance with Eating or Drinking Notes	If 'Yes', outline the level of risk (low/medium/high) and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information
Cultural or Religious Food Practice	Select 'Yes' or 'No' if the person we support has any cultural or religious food practices.	Mandatory Information
Cultural or Religious Food Practice Notes	If 'Yes', outline the current food practices and indicate where Care Team members can access additional information if required. If 'No', state 'Not applicable'.	Mandatory Information
Encouragement to Eat	Select 'Yes' or 'No' if the person we support requires active encouragement to eat their food.	Mandatory Information
Encouragement to Eat Notes	If 'Yes', outline the level of risk (low/medium/high) and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information
Food Allergies/ Adverse Reactions	Select 'Yes' or 'No' if the person we support has any food allergies/adverse food reactions.	Mandatory Information
Food Allergies/ Adverse Reactions Notes	If 'Yes', ensure formation under the following headings, <ul style="list-style-type: none"> <li>Level of Risk (Low, Medium, High)</li> <li>Brief Description of Behaviour/Risk</li> <li>Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> </ul>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	<ul style="list-style-type: none"> <li>Crisis Support Strategies (Strategies/actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p>	
Left or Right-Handed	Select 'Left' or 'Right' handed as per the person we support's preference.	Mandatory Information
Meals Served	Select the most appropriate option regarding how the person we support's meals should be served.	Mandatory Information
Nutrition Plan	By virtue of MC programs having Menu Plans, every person we support has a nutrition plan and should have this answered as 'Yes'.	Mandatory Information
Nutrition Plan Notes	For all people we support state, 'As per menu planner'. For people we support who have specific nutrition plans developed via medical professions, indicate the location of this plan (e.g., Goal Plan).	Mandatory Information
Special Aids for Eating or Drinking	Select 'Yes' or 'No' if the person we support has any special aids to supporting eating or drinking.	Mandatory Information
Special Aids for Eating or Drinking Notes	If 'Yes', outline the level of risk (low/medium/high) and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information
Special Diet Requirements	Select 'Yes' or 'No' if the person we support has any special diet requirements.	Mandatory Information
Special Diet Requirements Notes	If 'Yes', outline the level of risk (low/medium/high) and indicate where additional strategies are provided for Care Team members (e.g., Goals Plan). If 'No', state 'No present concerns'.	Mandatory Information
Tube Feeding Required	Select 'Yes' or 'No' if the person we support requires a feeding tube.	Mandatory Information
Tube Feeding Required Notes	If 'Yes', outline the level of risk (low/medium/high) and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information
Utensils Used	Select the appropriate utensils that the person we support uses. More than one can be selected.	Mandatory Information
Utensils Used Notes	Add any relevant notes, such as if plastic or metal cutlery are used.	Mandatory Information

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## Menstruation

CTARS Field Name	Type of information for Field	Information Category
Assistance Required	Select 'Yes' and 'No' depending on if the person we support required support with managing their menstruation. If menstruation is not relevant, select 'No'.	Mandatory Information
Assistance Required Notes	<p>If 'Yes', ensure formation under the following headings,</p> <ul style="list-style-type: none"> <li>• Level of Risk (Low, Medium, High)</li> <li>• Brief Description of Behaviour/Risk</li> <li>• Proactive Support Strategies (Strategies that the Care Team use to reduce risk on a regular basis)</li> <li>• Crisis Support Strategies (Strategies/ actions the Care Team use when the person we support is in crisis and ensuring safety has become the primary focus)</li> </ul> <p>If there is no evidence of this behaviour, state 'Not currently present'.</p> <p>If menstruation is not relevant, state 'Not applicable'.</p>	Mandatory Information
Duration of Menses' (day)	Provide an approximation of the number of days. If menstruation is not relevant, state 'Not applicable'.	Mandatory Information
Sanitary Products Used	Identify the type of sanitary products the person we support prefers. If menstruation is not relevant, state 'Not applicable'.	Mandatory Information

## Mobility and Movement

CTARS Field Name	Type of information for Field	Information Category
Difficulty moving on uneven or rough ground (Assess Risk)	Select 'Yes' and 'No' depending on if the person we support experiences difficulty moving on uneven or rough ground.	Mandatory Information
Difficulty moving on uneven or rough ground (Assess Risk) Notes	If 'Yes' outline the level of support required (low/medium/high) and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information
Hearing or Vision Impaired (Assess Risk)	Select 'Yes' and 'No' depending on if the person we support experiences hearing or vision impairment.	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Hearing or Vision Impaired (Assess Risk) Notes	If 'Yes', outline the level of support required (low/medium/high) and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information
Mobility Level (Assess Risk)	Select the most appropriate option relating to the person we support's mobility level. More than one can be selected if needed.	Mandatory Information
Mobility Level (Assess Risk) Notes	Provide additional details or information regarding special equipment or aids needed. If none required, state 'No supports required'.	Mandatory Information
Other Mobility or Movement Issues	Select 'Yes' and 'No' depending on if the person we support had other mobility or movement issues.	Mandatory Information
Other Mobility or Movement Issues Notes	Provide additional details or information regarding the person we support's level of mobility. This may be situation specific, such as unable to lift items or bend over.	Mandatory Information
Special Aids Required	Select 'Yes' and 'No' depending on if the person we support requires special aids.	Mandatory Information
Special Aids Required Notes	If 'Yes', outline the level of support required (low/medium/high), list the specific items that are used and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information
Travelling in a Vehicle	Select 'Yes' and 'No' depending on if the person we support requires additional aids to safely travel in a car.	Mandatory Information
Travelling in a Vehicle Notes	If 'Yes', outline the level of support required (low/medium/high), list the specific items that are used and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information

### Sun Safety

CTARS Field Name	Type of information for Field	Information Category
Sun Safety	All people we support are supported to engage in sun safety practices. Select 'Yes'.	Mandatory Information
Sun Safety Notes	Provide details on the level of support the person we support requires to follow basic sun safety practices. This may include reference to them needing hurdle help to have a hat, use sunscreen and be aware of sunstroke prevention.	Mandatory Information

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### Swimming and Water Sports

CTARS Field Name	Type of information for Field	Information Category
Independently Swim	Select 'Yes' and 'No' depending on if the person we support can independently swim (does not require physical support while in the water to be safe). <b>Note:</b> completed a CTARS High Risk Activity form for swimming activities.	Mandatory Information
Independently Swim Notes	If 'No', outline the level of support required (low/medium/high) and provide strategies and supports the Care Team should use. If 'Yes', state 'No present concerns'.	Mandatory Information
Participate in Swimming or Water Sports	Select 'Yes' and 'No' depending on if the person we support is able to participate in swimming or water sports.	Mandatory Information
Participate in Swimming or Water Sports Notes	If 'No', outline the main reason and provide strategies and supports the Care Team should use. If 'Yes', state 'No present concerns'.	Mandatory Information
Support whilst in the water	Select 'One on One' support if the person we support requires one on one support from a carer when swimming. Select 'Two on One' support if the person we support can safely have one (1) carer supervise two (2) people we support when swimming.	Mandatory Information
Support whilst in the water Notes	Comment on the type of supervision required (e.g., line-of-sight/care at pool edge/carers in the water).	Mandatory Information
Wheelchair Access Required	Select 'Yes' and 'No' depending on if the person we support requires wheelchair access when engaging in swimming.	Mandatory Information
Wheelchair Access Required Notes	If 'Yes', outline the level of support required (low/medium/high), list the specific items that are used and provide strategies and supports the Care Team should use. If 'No', state 'No present concerns'.	Mandatory Information

### Toileting

CTARS Field Name	Type of information for Field	Information Category
Assistance Required	Select 'Yes' and 'No' depending on if the person we support requires physical assistance with the following: <ul style="list-style-type: none"> <li>• Toilet paper</li> <li>• Washing hands</li> <li>• Special Aids or equipment</li> </ul>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Assistance Required Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task. If no support is required, state 'Support not required'.	Mandatory Information
Aware of needing to use toilet	Select 'Yes' and 'No' depending on if the person we support is able to independently identify that they need to use the toilet while awake.	Mandatory Information
Aware of needing to use toilet Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task. If no support is required, state 'Support not required'.	Mandatory Information
Constipation – any signs, symptoms or behaviour changes	Select 'Yes' and 'No' depending on if there are clear signs and indications that the person we support is experiencing constipation.	Mandatory Information
Constipation – any signs, symptoms or behaviour changes Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task. If unknown state 'Symptoms can include a challenge going to the toilet, bloated stomach or stomach pains'.	Mandatory Information
Constipation – prescribed by doctor	Select 'Yes' and 'No' depending on if the person we support has medication prescribed as a PRN for constipation.	Mandatory Information
Constipation – prescribed by doctor Notes	If 'Yes', state 'Referee to Medication Chart'. If no support is required, state 'Support not required'.	Mandatory Information
Distinguish Public Toilet – Male/ Female Signs	Select 'Yes' and 'No' depending on if the person we support is able to appropriately distinguish between male and female public toilets.	Mandatory Information
Distinguish Public Toilet – Male/ Female Signs Notes	If 'Yes' or 'No', enter details on how the Care Team are to assist the person we support with the task. If no support is required, state 'Support not required'.	Mandatory Information
Fully Independent Toileting	Select 'Yes' and 'No' depending on if the person we support is able to independently complete the task of going to the toilet by themselves.	Mandatory Information
Fully Independent Toileting Notes	If 'Yes' or 'No', enter details on how the Care Team are to assist the person we support with the task. If no support is required, state 'Support not required'.	Mandatory Information
Inappropriate Behaviours Relating to Toileting	Select 'Yes' and 'No' depending on if the person we support displays inappropriate behaviour relating to toileting.	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Inappropriate Behaviour Relating to Toileting Notes	If 'Yes' or 'No', enter details on how the Care Team are to assist the person we support with the task. If no support is required, state 'Support not required'.	Mandatory Information
Incontinent	Select 'Yes' and 'No' depending on if the person we support has issues with incontinence.	Mandatory Information
Incontinent Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task. If no support is required, state 'Support not required'.	Mandatory Information
Preferred ways of toileting	Select 'Yes' or 'No' depending on if the person we support has expressed a preferred way of toileting (standing/sitting).	Mandatory Information
Preferred ways of toileting Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task. If no support is required, state 'Preference not stated'.	Mandatory Information
Routine – Day Time	Outline if the person we support has specific toileting routines during the day. This may be linked with medication, disability support or age required learning. If no specific routine, state 'No identified routine'.	Mandatory Information
Routine – Night Time	Outline if the person we support has specific toileting routines during the night. This may be linked with medication, disability support or age required learning.	Mandatory Information
Toilet Timed	Select 'Yes' and 'No' depending if the person we support requires assistance around the duration they spend on the toilet or support with toilet scheduling. This can record both elements depending on the need of the person we support.	Mandatory Information
Toilet Timed Notes	If 'Yes' or 'No', enter details on how the Care Team are to assist the person we support with the task. If no support is required, state 'Support not required'.	Mandatory Information
Use Continence Aids	Select 'Yes' and 'No' depending on if the person we support uses continence aids.	Mandatory Information
Use Continence Aids Notes	If 'Yes' or 'No', enter details on how the Care Team are to support the person we support with the task. If no support is required, state 'Support not required'.	Mandatory Information

### Medication Module

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The [Medication Module](#) within CTARS plays the function of both recording current, approved medication and the location for entering administered medication data. This function is a critical part of maintaining the integrity of the medication management processes within RCaTS.

### Medicine Management

This is located under the [Medication](#) tab. This section of the [Medication Module](#) holds all medications that have been entered to be provided to clients. There are several medications that are already entered into this section, these include common medication types, however, CTLs are able to add new medications into CTARS as needed. On the main [Medicine](#) page, there are three (3) [Actions](#) that different roles can engage in – [View](#), [Edit](#) and [Deactivate](#). It is critical that any actions to [Edit](#) or [Deactivate](#) medicines are actioned in consultation with the Clinical Lead. This is due to any changes potentially affecting other clients also prescribe the medicine and will result in changes to historical records.

CTARS Field Name	Type of information for Field	Information Category
Add Medicine (if medication not listed)	Add a new medicine type by clicking the Add Medicine button. Complete all sections and save.	Mandatory Information
Medicine Name	Type in the name of the medicine as listed on the prescription and package. This should be the medicine name, not the medicine brand name (e.g. Paracetamol - a.k.a., Panadol, Panamax, Dymadon, Tylenol, etc.). Update with the 'Edit' function when adding medication.	Mandatory Information
Side Effects	List all known side effects as indicated on the prescription and package. If this is not listed, ensure to gather this information from pharmacist or prescribing doctor.	Mandatory Information
Dose Form	Select from the drop-down list the correct way the medicine is applied. This must be exact, if the correct form is not listed, contact a Super User to have the correct form added.	Mandatory Information
Unit of Measure and Concentration	Select from the drop-down list the correct unit of measurement/concentration as listed on the prescription and package. This must be exact, if the required measurement is not listed, contact a Super User to have the correct unit added.	Mandatory Information
Timing	Select from the drop-down list the correct timing for when the medicine should be administered as stated on the prescription and package. This must be exact, if the required timing is not listed, contact a Super User to have the correct timing added.	Mandatory Information
Route of Administration	Select from the drop-down list the correct way that the medication should be administered to the person. This must be exact, if the required route	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	of administration is not listed, contact a Super User to have the route added.	

### Medication Chart

This is located under the [Medication](#) tab. This section of the [Medication Module](#) manages the [Medication Charts](#) for each person we support. This section has two (2) main functions. Firstly, to display the current approved and pending medicines within a client's Chart and secondly, to add new/updated [Medication Charts](#) for people we support.

The main page in this section displays the people we support assigned to a worker's profile hierarchy and provides a brief summary of the number of approved and pending plans. By clicking on the arrow to the left of the person we support's profile picture, a more in-depth summary is provided, along with possible actions of [View](#), [Approve](#) or [Deactivate](#), depending on the permissions of the worker's role.

### Adding a Medication Chart

CTARS Field Name	Type of information for Field	Information Category
Add Medication Chart	Add a new Medication Chart by clicking the <a href="#">Add Medication Chart</a> button. Complete all sections and save.	Mandatory Information
Select a client	From the drop-down list, select which client the Medication Chart is connected to.	Mandatory Information
Start Date	Select the date that the medication is due to start, this is the date the client will start being provided with the medication.	Mandatory Information
Stop/Review Date	Select the date that the medication is either due to stop (as per prescription or prescribing doctor instruction) <b>or</b> the client is due to have a medication review appointment. The end date on the medication chart should be no longer than 3 monthly. Most medication reviews appointments occur quarterly. Ensure this date is saved in the CTL's calendar, as once the date has passed, the medication will stop appearing for administration.	Mandatory Information
Medicine Name	Select from the drop-down list the name of the medicine as listed on the prescription and package. Ensure the medication selected has the correct medication data before continuing. If the medication name is not listed, return to the <a href="#">Medicine Management</a> section to add the medication before continuing.	Mandatory Information
Dosage	Enter the prescribed dosage, as per the prescription. This number should reflect the quantity that the person we support is given, such as grams per tablet or millilitres of liquid. This	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	number does not reflect the number of tables, but rather the total grams per dosage the person we support should take. For example, the person we support needs 30gm, however takes 2x15gm tables. The dosage number entered is 30.	
Unit of Measure and Concentration	This section will auto-populate from the <a href="#">Medication Management</a> data. Ensure this is correct for the client before continuing. If this is not accurate, return to the <a href="#">Medication Management</a> section.	Mandatory Information
Dose Form	This section will auto-populate from the <a href="#">Medication Management</a> data. Ensure this is correct for the person we support before continuing. If this is not accurate, return to the <a href="#">Medication Management</a> section.	Mandatory Information
Route of Administration	This section will auto-populate from the <a href="#">Medication Management</a> data. Ensure this is correct for the person we support before continuing. If this is not accurate, return to the <a href="#">Medication Management</a> section.	Mandatory Information
Timing	This section will auto-populate from the <a href="#">Medication Management</a> data. Ensure this is correct for the person we support before continuing. If this is not accurate, return to the <a href="#">Medication Management</a> section.	Mandatory Information
Dose Frequency	Select from the drop-down list when the person we support is prescribed to take the medication. Depending on what is selected, additional boxes will appear to enter at the exact time the medication is due. If the medication is due once a day in the morning, one (1) additional box will appear titled 'Time 1' to enter the time the medication is due. If the medication is due three (3) times a day, three (3) additional boxes will appear titled, 'Time 1', 'Time 2' and 'Time 3' to allow the exact time of each administration to be entered.	Mandatory Information
Prescribed By	Enter the name of the Prescribing doctor.	Mandatory Information
Monitoring Required	This button is currently not in action – leave unticked.	N/A

### Approving a Medication Chart

Once a Medication Chart has been entered it is [Pending](#) and requires approval. This process allows for double-checking of information to ensure accuracy. To approve a medication, it is required that the CTL views (either in person or by photo) the actual medication (such as the

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Webster pack/box/bottle) as provided by the Pharmacist with a label containing the person we support's name. This is generally completed by the CTL but can be completed by Area Coordinator (AC) or On-Call in relevant situations. The person approving the medication is required to save the image to the [Documents](#) section of CTARS under the person we support's [Health](#) section to evidence the check. Medication waiting approval will have an extra [Action](#) available depending on the worker's role permissions to complete this task. To complete the approval, click the [Approval](#) action next to the [Pending Medication Chart](#), this will display the Chart for review. Compare the CTARS Chart information with the actual medication package information to ensure they both match. If the information is incorrect, return to the Medication Chart and edit the Chart to ensure it is correct. If the information is correct, the Chart can be approved.

In some cases, medication is not provided on selected days, such as only given on school days or only on the weekend or on alternate days. In this case, this can be configured by **ticking the 'Ignore' box for the not required medications** in the list below the Chart before approving.

**Note:** Medication Charts can be set up in advance for instances where medication is due to expire outside of business hours.

### [Deactivation of Medication Charts](#)

Medication Charts that have expired or are no longer required are to be deactivated. To deactivate a medication chart log into CTARS and select the [Medication](#) tab from the menu. Click [Medication Chart](#) then choose the relevant person we support.

In the [Treatment Plan](#) section, identify the required plan to be deactivated and identify the desired medication to be deactivated. Click on the [Deactivate](#) button; when asked if you are sure you want to deactivate the medication chart, click yes.

If required to reactivate a deactivated chart, click on the [Inactive Folders](#), identify the chart, and make active.

### [Daily Medication](#)

The [Daily Medication](#) section is the most frequently used function of the [Medication Module](#). This is located under the [Medication](#) tab. This section is where the medication is listed as administered or not, on any given day/time. This section receives information from the Medication Chart and schedules the medication to appear that the correct time, frequency, and day. There are five (5) different tabs in this section, all with their own individual purpose. The information in this section is viewed one person we support at a time, which can be filtered by the [Select Client](#) drop-down box at the top of the page and by [From](#) and [To](#) dates. The page will default to the last month as a timeframe.

### [Due](#)

The [Due](#) tab displays medication that is *due that day*. All medication that the client is prescribed to have that calendar day will be listed here and automatic refresh every day. All needed information about the medication is listed, including the Medicine Name (as per prescription), Dosage-UOM (Unit of Measurement)-Dose Form, Timing, Route of Administration, Due (date and time). In addition to this information, there are possible actions available; Time Taken and Dose Omitted. Only one of these actions is needed; either the medication was taken or omitted. While medication is sitting in the [Due](#) tab, [Time Taken](#) or [Dose Omitted](#) can be entered and saved.

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### ***Time Taken***

To enter that the medication was taken, either type in the actual time the medication was taken (including AM or PM) or select the time from the dropdown options (noting either AM or PM). Once the actual time the medication was taken is entered, click the [Save](#) button to complete.

### ***Dose Omitted***

The [Dose Omitted](#) tab displays all medications that were NOT administered to the person we support, alongside the reason why it was omitted, and the name of the worker who logged it as omitted. This tab is a record of past logs and is critical in understanding medication effectiveness and possible impacts on health and behaviour.

If the medication was not taken as prescribed, it has been omitted. Select a reason from the dropdown list below the [Dose Omitted](#) column. It is critical that the reason is accurate and that additional information regarding why the person we support did not take their prescribed medication is entered into the AM or PM [Shift Logs](#), under the [Medication](#) question.

Medication will only remain in the [Due](#) tab up until one (1) hour past the due time. After this time the medication will move to the [Dose Omitted No Reason](#) tab.

### ***Dose Omitted No Reason***

Like the [Due](#) tab, the [Dose Omitted No Reason](#) tab is often used by workers logging medication. As noted above, medication will move from the [Due](#) tab to the [Dose Omitted No Reason](#) tab one (1) hour past its due time. This is expected and at this stage there is no error. As with the [Due](#) tab, there are two (2) possible actions; Time Taken or Dose Omitted. Medication will remain in this tab until either the Time Taken or Dose Omitted actions are completed. It is important for CTLs to check the [Daily Medication](#) for the people we support, each day, to ensure medication is being logged correctly.

### ***PRN***

The [PRN](#) tab holds all currently approved PRN medications for that person we support. PRN refers to medications that are taken as needed. The term PRN is taken from the Latin “pro re nata”, which means “as the thing is needed”. Often, pain support medications, such as Panadol, are listed for use as a PRN, however, due to possible side effects of other medications, all PRN medication must be approved on an individual case.

The [PRN](#) tab will display all medications approved, and an action of [Time Taken](#) is available. PRN medications may have different levels of approval to provide to the client, this information is critical for everyone to have access to before administering medication. Once the PRN medication has been provided, the actual time taken is entered into the [Time Taken](#) field (noting AM and PM) and the [Save](#) button is clicked to confirm.

### ***Administered***

The [Administered](#) tab displays the records of all medication that has been successfully administered for a particular person we support. This section shows the Medication Information,

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Time Due, Time Taken and who logged the entry. This information can be very helpful in following up any queries or issues with medication.

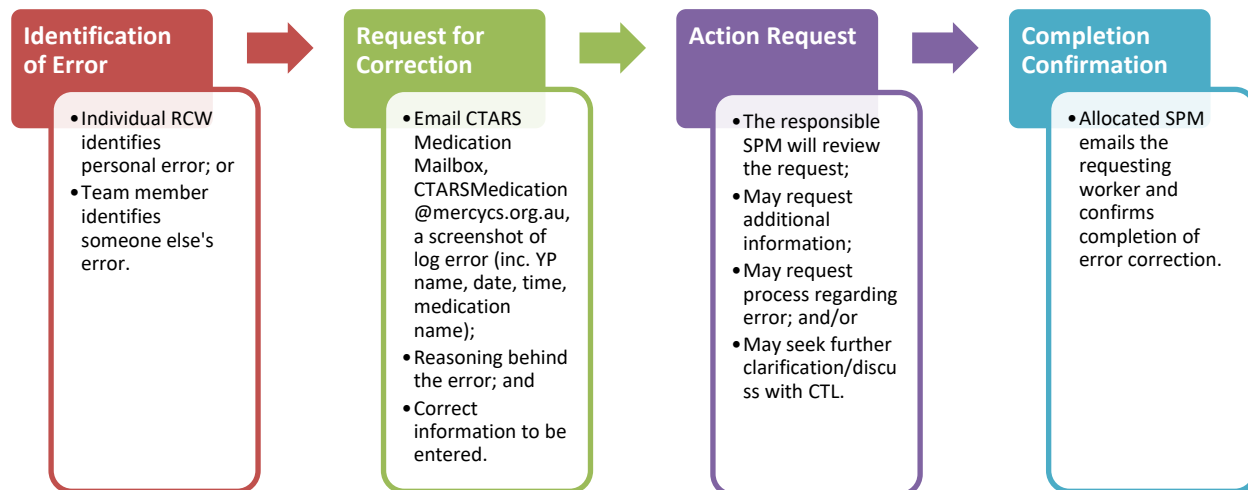
### Medication Error

It is acknowledged that mistakes happen, and medication may, in rare cases, be logged incorrectly. If/when an error is identified, this is forwarded to the CTARS Medication Mailbox ([CTARSMedication@mercyys.org.au](mailto:CTARSMedication@mercyys.org.au)) and the relevant CTL with the following information:

- Screen shot of the medication error (including details such as the person we support's name, date of entry, time entry was due and medication name);
- What the error is;
- Why this error occurred; and
- What the medication log should be corrected to.

This is then managed by the Senior Program Manager (SPM) to review (ensuring that the information aligns), follow up required information, and correct. The SPM has access to a [Revert](#) button within the [Daily Medication](#) tab to make the required corrections.

In the event there is information missing from the request, the SPM will respond to the email and request further information. If there are concerns regarding the request, this will be sent to the CTL for further discussion or clarification. Upon completion of the correction, the SPM will email the worker sending the request and the CTL to advise.



### Summary Report

The [Summary Report](#) within the [Medication Module](#) generates a display of critical medication information and a list of medications that were active during the selected timeframe.

This information is often helpful for medical appointments and professions, such as medication reviews/changes and support information for a new General Practitioner (GP). This information cannot be exported from CTARS in this format at this time, however a screenshot or PDF can be taken. Whenever this is a change has been made to medication, the CTL is required to take a

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screenshot or PDF of the updated Medication Summary to send to the Care Team email distribution list so it can be updated in the Unit Folder by the Senior RCW (SRCW) or Care Team.

### Case Planning

This section of the profile provides information regarding the Departmental Case Planning and MC therapeutic goals.

#### Case Plan

CTARS Field Name	Type of information for Field	Information Category
Case Plan	Select 'Yes' or 'No', relating to if a Departmental Case Plan has been provided from the Department to MC.	Mandatory Information
Current Case Management Responsibility	Select who is currently holding case management for the person we support. For majority of the people we support under Child Protection orders, this will be "Community Services". This is referencing Department Community Services.	Mandatory Information
Agency Providing Case Management Services	This is the Child Safety Service Centre that the person we support is associated with.	Mandatory Information
Goal of Case Plan (Placement)	This is referring to the main overarching permanency planning goal for the person we support, this goal is set by Child Safety. Select the most appropriate option from the drop-down box.	Mandatory Information
Included Case Plan Elements	Select which Case Plan elements have been provided to MC by Child Safety. If there are elements that are required for the person we support (such as Cultural Support Plan or Transition to Adulthood Plan) that have not been provided to MC from Child Safety, note the dates that these have been requested by MC in the Notes section below. Multiple can be selected. <ul style="list-style-type: none"> <li>Select 'Other' for Placement Agreements.</li> <li>Select 'Therapeutic Plan' for people we support who are connected to Evolve Therapy Services.</li> </ul> <i>Note: Required information for Quarterly Reporting.</i>	Mandatory Information
Behaviour Support Plan ID	This is referencing NDIS Support Plan ID number. Enter the corresponding NDIS Support Plan ID number. If this is not relevant to the person we support, state 'No NDIS Plan'.	Mandatory Information
Case Plan Date Created	This is the date of the current Departmental Case Plan on file.	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Case Plan Review by Date	This is the date that the Departmental Case Plan is next due to be reviewed by Child Safety representative.	Mandatory Information
Case Plan Review Last Conducted Date	This is the date of the previous review of the Departmental Case Plan (the case plan before the current case plan). If this is unknown, leave blank.	Mandatory Information
Notes	If there are Departmental Case Plan elements that are required for the person we support (such as Cultural Support Plan or Transition to Adulthood Plan) that have not been provided to MC from Child Safety, note the dates that these have been requested by MC in this section.	Mandatory Information

### Restrictive Practice

CTARS Field Name	Type of information for Field	Information Category
Add Restrictive Practice	Select the <a href="#">Add Restrictive Practice</a> button, complete all sections and save. Not all people we support have Restrictive Practice noted by the Department's or in NDIS Behaviour Support Plans. If no restrictive practices have been noted by the Department for the person we support, do not enter information in this section.	Non-mandatory Information
Practice	Enter the name of the type of Restrictive Practice. Enter one of the following: <ul style="list-style-type: none"> <li>Physical</li> <li>Removal of Object</li> <li>Transport</li> <li>Medication</li> </ul>	Mandatory Information
Restrictive Practice Status	Select if the Restrictive Practice status is 'Active' and 'Inactive'. This should be updated on review.	Mandatory Information
RPA Start Date	Enter the date that the Restrictive Practice started.	Mandatory Information
Restrictive Practice Inactive Date	Enter the date that the Restrictive Practice has been inactive. If the Restrictive Practice is still in use, leave blank.	Mandatory Information
Type	Select the appropriate type of practice.	Mandatory Information
RPA Description	Enter text description of the Restrictive Practice. This information can be found in the TAR.	Mandatory Information
RPA Panel Date	This the referring to the Formulation date or the Stakeholder meeting date when the Restrictive Practice was discussed.	Mandatory Information
RPA Panel Outcomes	Select the most appropriate outcome from the formulation/stakeholder meeting.	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
Review Date	This date corresponds with the next TAR review date.	Mandatory Information
Expiry Date	The date relates mainly to medication Restrictive Practices.	Mandatory Information
Consenter	Select the relevant roles who have consented/ approved to the use of the Restrictive Practice.	Mandatory Information
First Approved Date	Enter the date that the practice was approved on by the above consenters.	Mandatory Information

### Benchmark

During the first two (2) weeks of a person we support's placement, the CTL is required to set up the individualised Benchmark values within the [Client Profile](#). Once these Benchmark values have been set up, they will often remain the same while the person we support is placed within the program. However, there are inconsistencies when a CTL would be required to update the Benchmark values due to a change in the person we support's situation (such as a change in Family Contact frequency) or their personal capacity has changed/developed (such as increased school attendance or reduced need to attend Therapy Sessions). When the Benchmark values are first set up, the CTL also entered the '[Entry](#)' [Benchmark value](#), which is used as a comparison point for growth and change during the placement. This action of setting the Benchmark entry values is critical in enabling future analysis of behaviour changes and trends.

To enable reflection and understanding of the life goals and behavioural targets of the person we support, a [Benchmark Goal](#) needs to be set to indicate what the 'expected' engagement/target is for the person we support across many domains. By having Benchmark Goal outlined, it enables clinical analysis and reflection on the current progress that the person we support is demonstrating.

There are three (3) fields that relate to each Benchmark domain. Below are the definitions of each field and the information required.

Benchmark Goal	Goal Achieved	Entry
This field should include an attainable score, reflecting the number of times in the month you would like to see the person we support achieve each item, in order to meet their goals.	This field should be used to identify any stipulations of goal achievement. Most commonly this refers to a timeframe or review period for achievement, or a dependency for goal achievement.	This field refers to the person we support's benchmark on entry to the services. This reflects the starting point for measuring the person we support's benchmarks and will only change when the person we support experiences a significant change in services. This should help the reader of the Benchmark Report to reflect on the person we support's progress to goal

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Benchmark Goal	Goal Achieved	Entry
		achievement throughout the program.

There are thirty-six (36) Benchmark Domains that require an individualised Benchmark Goals to be entered for each person we support. Some of these domains tend to be very similar for many person we support, such as the goal of waking up on time every morning or engaging in weekly Reference Person Meetings with their CTL. However, other domains will be very individualised such as Family Contact and Leaving Care/Transition Goals. To provide support in setting meaningful and reflective values, below outlines what each Benchmark Domain is referring to, what this domain is potentially an indicator of suggestions of ideal benchmarks and suggestions of how to display the values in the most appropriate way.

The following section provide direction and instruction regarding completing the person we support's Benchmark values.

Domain	Benchmark Goal	Goal Achieved	Entry
Bedtime	The expected number of times the person we support will meet their set bedtime. This is an indicator of if the person we support is following their bedtime routine and going to bed at the set time. This is ideally benchmarked at every night. The Benchmark Goal field requires text information, such as 'Daily'.	The Goal Achieved field is used to provide context to Benchmark Goal. For example, if the benchmark is set to 'Daily', this field may state 'Daily', or 'As per planner'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month.
Diet Plan AM	The expected number of times the person we support will engage with their morning meal planner (breakfast and morning tea). This is an indicator of if the person we support is following both their morning routine and eating a healthy diet as set in accordance with age and health needs. This is ideally benchmarked as Daily. The Benchmark Goal field requires text	The Goal Achieved field is used to provide context to Benchmark Goal. For example, if the benchmark is set to 'Daily', this field may state 'Daily', or 'As per planner'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month.

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Domain	Benchmark Goal	Goal Achieved	Entry
	information, such as 'Daily'.		
Diet Plan PM	The expected number of times the person we support will engage with their afternoon meal planner (lunch and afternoon tea). This is an indicator of if the person we support is following both their afternoon routine and eating a healthy diet as set in accordance with age and health needs. This is ideally benchmarked as daily. The Benchmark Goal field requires text information, such as 'Daily' or 'Monthly'.	The Goal Achieved field is used to provide context to Benchmark Goal. For example, if the benchmark is set to 'Daily', this field may state 'Daily', or 'As per planner'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month.
Diet Plan Night	The expected number of times the person we support will engage with their evening meal planner (dinner and evening snacks). This is an indicator of if the person we support is following both their evening routine and eating a healthy diet as set in accordance with age and health needs. This is ideally benchmarked as daily. The Benchmark Goal field requires text information, such as 'Daily' or 'Monthly'.	The Goal Achieved field is used to provide context to Benchmark Goal. For example, if the benchmark is set to 'Daily', this field may state 'Daily', or 'As per planner'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month.
Education/ Vocation <i>Note: This is one of the Benchmark values that should be updated every month before</i>	The expected number of times the person we support will engage in their planned education program (such as formal schooling or TAFE). This is an indicator of the frequency of	The Goal Achieved field is used to provide context to Benchmark Goal. For example, if the benchmark is set to '0', this field may state 'Currently in school	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month.

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Domain	Benchmark Goal	Goal Achieved	Entry
<i>producing the Benchmark Report</i>	engagement in the education program. This benchmark should be set to reflect the agreed program attendance per day (even if this is only a half day attendance) and take into consideration weekends. For full time school attendance, this is generally between 18 and 22 days per month. During school holidays this should be set to '0'. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.	holidays' or 'Currently suspended from school.'	
Centre Based Program <i>Note: This is one of the Benchmark values that may needed to be updated every month before producing the Benchmark Report</i>	The expected number of times the person we support is planned to attend internal MC based program activities. This is an indicator of the person we support's program compliance and their engagement in structured activities. This benchmark may be linked with engaging in placement placed activities, such as the Cultural Learning Project. This is generally benchmarked at around 4 engagements a month, however, may be more. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.	The Goal Achieved field is used to provide context to Benchmark Goal. For example, this field may state the name of the program they are engaging with.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month.
Community Participation	The expected number of times the person we support is planned to engage with their local community. This is an	The Goal Achieved field is used to provide context to Benchmark Goal. For example, this field may state which	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31,

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Domain	Benchmark Goal	Goal Achieved	Entry
	<p>indication of the amount of community participation the person we support is expected to be able to manage safely and with success. Although this number is set to indicate benchmark of planned community engagement, Activity Logs will record other unplanned or ad hoc community participation. This is benchmarked in line with the safety and capacity of the person we support and should increase as they progress through the Phased Trauma Recovery Model and is set for number of engagements within one (1) month. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.</p>	<p>phase the person we support is in, such as 'In line with independent time plan' or 'Planned Activities'.</p>	<p>representing the times achieved during a month.</p>
<p>Employment</p> <p><i>Note: This is one of the Benchmark values that may need to be updated every month before producing the Benchmark Report</i></p>	<p>The expected number of times the person we support is planning to attend their employment. This is an indicator of building independent living skills of financial security and management of life commitments. This is benchmarked on their current employment roster over one month. This may not yet be a goal for some people we support due to their age, in this case set as 0. The Benchmark Goal field requires a set number (not a text field)</p>	<p>The Goal Achieved field is used to provide context to Benchmark Goal. For example, 'As per roster', or 'Not age relevant goal'.</p>	<p>Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month.</p>

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Domain	Benchmark Goal	Goal Achieved	Entry
	for the month to be entered.		
<b>Vocational</b> <i>Note: This is one of the Benchmark values that may need to be updated every month before producing the Benchmark Report</i>	The number of times the person we support is planned to attend vocational activities. This may include participation in programs to learn specific skills and talents, such as art, music, and technical skills. This is not group sports or clubs, however, may be private lessons or tuition. This is benchmarked on the person we support's current engagement in planned activities, however, will be influenced by their progression through the Phase Trauma Recovery Model, with expected increased engagement during the Targeted Therapeutic Phase. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.	The Goal Achieved field is used to provide context to Benchmark Goal. For example, if the person we support's vocational activities are in season/engaging in lessons or a break (such as during school holidays).	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month.
<b>Volunteering</b> <i>Note: This is one of the Benchmark values that may need to be updated every month before producing the Benchmark Report</i>	The number of times the person we support is planned to engage in a volunteering program. This may include engaging in community volunteering, RSPCA, church group activities or environmental activities. This is benchmarked on the person we support's current wish to engage in volunteering activities, however, will be influenced by their progression through the Phased Trauma	The Goal Achieved field is used to provide context to Benchmark Goal. For example, if the person we support is old enough to engage in formal volunteering.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

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Domain	Benchmark Goal	Goal Achieved	Entry
	Recovery Model with increased engagement during the Targeted Therapeutic Phase. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.		
Exercise AM	If the person we support is expected to engage in an in-program morning exercise activity. This may include walking to school or morning physical activities with the care team. For some people we support they may not engage in planned morning exercise, however, will have expectations to exercise in the afternoons. This is benchmarked against the person we support's daily plan, however, is ideally benchmarked for everyday of the month. The Benchmark Goal field requires text information, such as 'Daily', 'Weekly' or 'Monthly'.	The Goal Achieved field is used to provide context to Benchmark Goal. For example, may state 'Exercise set for afternoon engagement' or 'Walking to school during the week'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Exercise PM	If the person we support is expected to engage in an in-program afternoon exercise activity. This may include walking home from school or afternoon physical activities with the care team. It is expected that most people we support will have a planned afternoon exercise activity/opportunity. This is benchmarked against the person we support's	The Goal Achieved field is used to provide context to Benchmark Goal. For example, may state 'Exercise set for morning engagement' or 'In-program activities'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

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Domain	Benchmark Goal	Goal Achieved	Entry
	daily plan, however, is ideally benchmarked for everyday of the month. The Benchmark Goal field requires text information, such as 'Daily', 'Weekly' or 'Monthly'.		
Exercise Night Note: This is one of the Benchmark values that may need to be updated every month before producing the Benchmark Report	If the person we support is expected to engage in an in-program evening exercise activity. This may include group sport training or attending a gym with the care team. For some people we support they may not engage in planned evening exercise, however, will have expectations to exercise in the afternoons. This is benchmarked against the person we support's daily plan. The Benchmark Goal field requires text information, such as 'Daily', 'Weekly' or 'Monthly'.	The Goal Achieved field is used to provide context to Benchmark Goal. For example, may state 'No evening exercise' or 'Weekly sport training'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Family Contact Note: This is one of the Benchmark values that may need to be updated every month before producing the Benchmark Report	The number of times the person we support is planned to attend family contact events. This includes all types of family contact. This is benchmarked against the Child Safety Case Plan and Family Contact Approval Agreement and is set for number of contacts expected to occur during a month. The Benchmark Goal field requires text information, such as 'Daily', 'Twice a Week',	The Goal Achieved field is used to provide context to Benchmark Goal. For example, may state 'As per contact agreement', or 'No approved contact'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

Domain	Benchmark Goal	Goal Achieved	Entry
	'Every Second Weekend' or 'Monthly'.		
<b>Family Contact Phone</b> Note: This is one of the Benchmark values that may need to be updated every month before producing the Benchmark Report	The number of times the person we support has planned/approved phone contact with a family member. If family contact is restricted, the benchmark is set to the approved number of phone contacts allowed. However, if phone contact is not restricted, this would be benchmarked on the assessed plan for the person we support's access to a phone and ability to engage in calling family. This may be set as daily, weekly, or not at all depending on phone access and the person we support's age. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.	The Goal Achieved field is used to provide context to Benchmark Goal. For example, may state 'As per contact agreement' or 'No phone contact restrictions, can occur as per the person we support's wishes'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
<b>Family Contact Face-to-Face</b> Note: This is one of the Benchmark values that may need to be updated every month before producing the Benchmark Report	The number of times the person we support has planned/approved face-to-face contact with a family member. If family contact is restricted, the benchmark set to have the approved number of face-to-face contacts. However, if face-to-face contact is not restricted, this would be benchmarked on the assessed plan for the person we support's access to family members and ability to engage in planning to see family. This may be	The Goal Achieved field is used to provide context to Benchmark Goal. For example, may state 'As per contact agreement' or 'No face-to-face contact restrictions, can occur as per the person we support's wishes'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

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Domain	Benchmark Goal	Goal Achieved	Entry
	set as daily, weekly, or not at all depending on the family access and the person we support's age. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.		
General Illness	The number of times the person we support is expected to experience illness. This is generally set at '0' unless the person we support has a medical diagnosis that predicts periods of illness during the month. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.	The Goal Achieved field is to be used to provide context to the number. For example, if the benchmark is set to '0', the Goal Achieved field could state 'No Expected Illness'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Incident Note: This is one of the Benchmark values that may need to be updated every month before producing the Benchmark Report	The number of times the person we support is expected to engage in a behaviour that leads to an incident report being completed. Incident frequency is dependent on, or predicted by, a few factors. These include the person we support's progression through the Phased Trauma Recovery Model, the type of behaviours that the person we support displays and the level of targeted resilience building that is planned for the person we support. It is recommended to be realistic and project a minimum level of incidents to occur, rather	There is no Goal Achieved field for this Benchmark.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during the month before entry.

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Domain	Benchmark Goal	Goal Achieved	Entry
	than set the benchmark at '0'. However, if the person we support has transitioned into a low intensity support program and is expected to manage several challenges without support, this may be benchmarked at '0'. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.		
Legal/ Government Appointment	The number of times the person we support is expected to engage in legal or government appointments. This may include Youth Justice, contact with lawyers, CSO, Office of the Public Guardian (OPG) or Community Visitor (CV). This benchmark is highly reflective of the individual person we support's situation; however, it is expected that they will, at a minimum, have one (1) CSO visit every month. The Benchmark Goal field requires text information, such as 'Daily', 'Weekly' or 'Monthly'.	The Goal Achieved field is to be used to provide context to the text of the Benchmark. For example, 'Currently Engaged in Youth Justice Program'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Medical Appointments	The number of times the person we support is expected to have planned medical appointments. This is generally set at '0' unless the person we support has a medical diagnosis that predicts required medical appointments. This does	The Goal Achieved field is to be used to provide context to the number. For example, if the benchmark is set to '0', the Goal Achieved field could state 'No Expected Medical Appointments'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

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Domain	Benchmark Goal	Goal Achieved	Entry
	not include medication reviews. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.		
Medical Reviews	The number of times the person we support is expected to have planned medical reviews. This is generally set at '0' unless the person we support takes medication and has set medication review timeframes. The Benchmark Goal field requires a set number (not a text field) to be entered. As medication reviews generally occur on a planned yearly frequency, it is recommended to enter the expected number of medication review for the year and add context via the Goal Achieved field.	The Goal Achieved field is to be used to provide context to the number. For example, if the benchmark is set to '2', the Goal Achieved field could state 'Six Monthly Medication Review (April and October)'. This ensures that when the Benchmark report is produced (monthly basis), the reader can see when the next medication review is planned for and if the planned medication review occurred during that month.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Respite Goals	The number of times the person we support is expected to engage in respite care. This may be part of their transition out of care plan and includes approved respite with family or foster carers. This is different to family contact as the person we support is being supported to transition into the respite carers' full-time care or is returning to live with family. This benchmark is set depending on the individual person we support's situation. The	The Goal Achieved field is to be used to provide context to the number. For example, if the Benchmark is set at '0', the Goal Achieved field could state 'No Respite Carer Identified', or 'Respite is not a current goal'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

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Domain	Benchmark Goal	Goal Achieved	Entry
	Benchmark Goal field requires a set number (not a text field) for the month to be entered.		
Menstruation	The number of times the person we support is expected to menstruate during the month period. For people we support for whom this is not applicable for, set the Benchmark Goal '0' and Goal Achieved field as 'Not Applicable'. The Benchmark Goal Field requires a set number (not a text field) for the month to be entered.	The Goal Achieved field is to be used to provide context to the number. For example, if the Benchmark is set at '1', the Goal Achieved field could state 'Once per month'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Personal Care AM	The number of times the person we support is expected to engage in their morning personal care/hygiene routine. This is an indicator of if the person we support is following their personal care/hygiene routine and maintaining correct personal care. This is ideally benchmarked at every morning of the month. The Benchmark Goal field requires text information, such as 'Daily'.	The Goal Achieved field is to be used to provide context to the Benchmark. For example, 'AM Routine Challenges Impacted by Poor Sleep Patterns'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Personal Care PM	The number of times the person we support is expected to engage in their afternoon personal care/hygiene routine. This is an indicator of if the person we support is following their personal care/hygiene routine and maintaining correct personal care. This is ideally benchmarked at	The Goal Achieved field is to be used to provide context to the Benchmark. For example, 'PM Routine Challenges Impacted by Cotenant Dynamic'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

Domain	Benchmark Goal	Goal Achieved	Entry
	every evening of the month. The Benchmark Goal field requires text information, such as 'Daily'.		
Personal Care Night	The number of times the person we support is expected to maintain their personal care/hygiene routine during the night. This is an indicator of if the person we support is following their personal care/hygiene routine and maintaining correct personal care, an example may be using the bathroom in the night correctly (not urinating in their room at night). This is ideally benchmarked at every night of the month. The Benchmark Goal field requires text information, such as 'Daily'.	The Goal Achieved field is to be used to provide context to the Benchmark, such as 'Night Routine Challenges Impacted by Night-time Bedwetting'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Reference Person Meeting (RPM)	The number of times the person we support is planned to have a Reference Person Meeting (RPM). An RPM is the planned visit from the CTL and often is linked with Psycho-education engagement. This is an indicator of the frequency and consistence of contact between CTL and the person we support. This is ideally set at four (4) visits a month (one (1) visit a week). The Benchmark Goal field requires a set number	The Goal Achieved field is to be used to provide context to the Benchmark, such as 'Weekly Visit with CLT'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

Domain	Benchmark Goal	Goal Achieved	Entry
	(not a text field) for the month to be entered.		
Living Skills	The number of times the person we support is planned to engage in active living skill building activities. This should be benchmarked for all people we support; however, the frequency will increase as children are moving towards transition and towards Phase 4 of the Phased Trauma Recovery Model. This benchmark is related to planned cooking activities or learning about public transport. This is ideally set for a minimum of four (4) a month (one (1) a week). The Benchmark Goal field requires a set number (not a text field) for the month to be entered.	The Goal Achieved field is to be used to provide context to the set number. For example, 'Focused on Age-Appropriate Living Skill' or 'Engaging NDIS Services for Targeted Support'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Social Skills	The number of times the person we support is planned to engage in active social skill building activities. This should be benchmarked for all people we support; however, the frequency will be impacted by the person we support's current ability to maintain safety when engaging with other, as well as their own personal social goals. This benchmark is related to youth group attendance or group activities. The Benchmark Goal field requires a set number	The Goal Achieved field is to be used to provide context to the set number, such as 'Focused on Structured Social Activities' or 'Engages in Unstructured Social Activities during Independent Time'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

Domain	Benchmark Goal	Goal Achieved	Entry
	(not a text field) for the month to be entered.		
Culture Engagement	The number of times the person we support is planned to engage in individually relevant cultural activities/interactions. This is an indicator of the cultural support plan and the person we support's level of engagement in their culture. This should be set with high consideration for the individual person we support's situation and reflect their wishes and goals. This may include large scale cultural events and individual meetings with cultural leaders or groups. This should also include in-program activities such as the Monthly Cultural Project within in each program. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.	The Goal Achieved Field is to be used to provide context to the set number.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Identity Development	This is the number of times the person we support is planned to engage in an activity that aims to support positive identity development. This is an indicator of helping the people we support to engage with age-appropriate developmental milestones and personal history understanding and knowledge. This may include engaging in Life Story work. This is	The Goal Achieved field is to be used to provide context to the set number.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

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Domain	Benchmark Goal	Goal Achieved	Entry
	high reflective of the individual person we support's situation and will be impacted by their progress through the Phased Trauma Recovery Model. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.		
Leaving/ Transitioning Care	This is the number of times the person we support is planned to engage in targeted activities to support leaving or transitioning out of care. This is an indicator of their level of engagement and readiness to progress with their transition. This will be benchmarked based on the individual situation of the person we support, however, is expected to be a high focus for people we support in the SIL Programs and possibly during Phase 4 of the Phased Trauma Recovery Model. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.	The Goal Achieved field is to be used to provide context to the set number. For example, 'Focused on Housing/Financial Security Pre-Transition' or 'Engaging Family in Behavioural Support Learning in Preparation for Transition Home'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Leisure, Sport, Recreation Note: This is one of the Benchmark values that may need to be updated every month before producing the	This is the number of times the person we support is expected to engage in planned sport, leisure, or recreational activities. This is an indication of their engagement in community/social/team activities. This may include weekend group	The Goal Achieved field is to be used to provide context to the set number.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

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Domain	Benchmark Goal	Goal Achieved	Entry
Benchmark Report	sport, individual/group sport lessons and activities for personal fun. It is important for all people we support to be engaged in some form of activity of this nature, however, this will be impacted by risk/safety concerns and the interests of the person we support. The Benchmark Goal field requires a set number (not a text field) for the month to be entered.		
Therapy Sessions Note: This is one of the Benchmark values that may need to be updated every month before producing the Benchmark Report	This is the number of times the person we support is expected to engage in external therapy sessions with a therapist. This may be therapy sessions with an Evolve Therapist. This is an indication of the person we support's engagement in the therapy sessions. The Benchmark Goal field requires text information, such as 'Daily' or 'Monthly'.	The Goal Achieved field is to be used to provide context to the set number, such as the services providing therapy.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.
Wake	The expected number of times the person we support will meet their set wake-up time. This indicates if the person we support is following their morning routine and getting out of bed at the set time. This is ideally benchmarked at every morning of the month. The Benchmark Goal field requires text information, such as 'Daily' or 'Monthly'.	The Goal Achieved field is to be used to provide context, such as 'Impacted by Poor Sleep Hygiene'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

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Domain	Benchmark Goal	Goal Achieved	Entry
Weight	This benchmark is generally only used when there are health concerns that are indicated by the person we support's weight. If there is no medically set 'goal weight' for the person we support, the Benchmark is to be set at '0', with the Goal Achieved field commenting 'No Goal Weight Set'. If a 'goal weight' has been set, the Goal Achieved field comments who has set the weight, such as 'Prescribing Doctor Recommended Goal Weight'. It is important to ensure that there is an Entry Weight added to enable a starting measure for reference in case of large/sudden weight changes.	The Goal Achieved field is to be used to provide context, such as 'No Goal Weight Set'.	Displayed capacity to meet this benchmark at entry into the program. This field requires a number out of 31, representing the times achieved during a month before entry.

### 3. File Storage

#### Client Document Function

The Client Document Function within CTARS provides a document filing structure and location to store information regarding the person we support in a secure location. This function can be viewed as a replication of a 'share file drive', which allows multiple people to access, upload and download files relating to the person we support.

#### File Structure

Each person we support within the CTARS system has a standardised file structure, which follows a pre-set flow. This file structure is arranged under tier levels, these are displayed in the table below. Refer to the *FS IP RCATS CTARS Folder Structure* for further information.

Tier One	Tier Two
1. Referral Information	<ul style="list-style-type: none"> <li>Referral Documents</li> <li>Email Correspondence</li> <li>RD Approval for Under 12's</li> <li>Authority to Care</li> <li>Case Plan received at time of referral</li> </ul>
2. Departmental Information	<ul style="list-style-type: none"> <li>Case Plan</li> <li>Placement Agreement</li> <li>Transition to Adulthood Plan (T2A)</li> <li>Incident Report Notification</li> <li>Correspondence</li> </ul>
3. Entry and Induction	<ul style="list-style-type: none"> <li>Welcome Kit Checklist</li> <li>Welcome Book</li> <li>Transition Plan</li> </ul>
4. Assessment and Intervention Planning	<ul style="list-style-type: none"> <li>Assessments</li> <li>Departmental File Review</li> <li>Therapeutic Assessment Report Correspondence</li> <li>Data Analysis Reports</li> <li>Safety Plans</li> <li>Covid Safety Plan</li> <li>Formulation/ Case Consult</li> <li>Psychoeducation</li> <li>Departmental Correspondence</li> </ul>
5. Cultural Support Plan	<ul style="list-style-type: none"> <li>Cultural Support plan</li> <li>Departmental Correspondence</li> </ul>
6. Client Visual Planning	<ul style="list-style-type: none"> <li>Activity Planner</li> <li>Routines</li> <li>Goal Based Incentives</li> <li>Person we support agreements and house rules</li> </ul>
7. Stakeholder Meetings	<ul style="list-style-type: none"> <li>Stakeholder meeting Minutes</li> </ul>
8. Education and Employment	<ul style="list-style-type: none"> <li>Education Support Plan/ Individual Flexible Learning Agreement</li> </ul>

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Tier One	Tier Two
	<ul style="list-style-type: none"> <li>• Reports</li> </ul>
9. Family and Significant Others	<ul style="list-style-type: none"> <li>• Contact notes</li> <li>• Genogram</li> </ul>
10. Finances	<ul style="list-style-type: none"> <li>• Centrelink</li> <li>• Rent Training Program</li> <li>• Bank Account</li> <li>• Savings and Budget</li> <li>• Tax File Number</li> </ul>
11. Health	<ul style="list-style-type: none"> <li>• NDIS</li> <li>• Prescriptions and Medication Summary</li> <li>• Medication Risk Management Plan</li> <li>• Health Correspondence</li> <li>• Returned Medication</li> </ul>
12. Safety and Wellbeing	<ul style="list-style-type: none"> <li>• Activity Safety Plans</li> <li>• Risk Assessments</li> <li>• Activity Consent</li> <li>• Pool Safety Plan</li> </ul>
13. Legal and identification	<ul style="list-style-type: none"> <li>• Identification</li> <li>• Legal</li> <li>• Youth Justice</li> </ul>
14. Life Story Work	<ul style="list-style-type: none"> <li>• Photographs and memorabilia</li> </ul>
15. SILP Tenancy	<ul style="list-style-type: none"> <li>• General Mock Tenancy Agreement</li> <li>• Tenancy Entry</li> <li>• Property Inspection</li> <li>• Financial Compensation</li> <li>• Participation Commitment</li> <li>• <i>Emergency Evacuation Drill</i></li> </ul>
16. Transition and Exits	<ul style="list-style-type: none"> <li>• Rental Agreements and Documentation</li> <li>• Transition plan</li> </ul>

### Naming Convention

To maximise ease of use and ensure compliance with the *FS PROC RCaTS Records Management*, it is critical to ensure that each document uploaded into the Client Document function follows the correct naming convention. The following table displays the standard file naming convention used.

It is important to ensure that the document name acronym aligns with the first letter of each word in the documents (e.g., Welcome Book – WB, Referral Record – RR, Entry and Induction Checklist – EIC, etc.).

Refer to *FS IP RCaTS Document Naming Conventions* for further information pertaining to naming conventions.

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Naming Convention Formula	Convention Example	Written Example
Person we support initials, year, month, date, document name acronym	AS 2020-04-21 PBSP	Adam Smith 2020-04-21 Positive Behaviour Support Plan

### Document Date Conventions


To ensure compliance with the *FS PROC RCaTS Records Management*, it is critical to follow the same document date conventions. The date used in the naming convention is reflective of the date the document becomes 'live'. This may also be thought of as the date the document is 'due' to be completed and shared. The date in the document's name is not reflective of the date it was created, or the date it is to be reviewed.

The only exception to this is found in the document date of the ATC, Case Plan and Placement Agreement. These documents reflect the date the date the ATC expires as well as the date the document was completed. This is designed to support auditing and to ensure that MC always has in date/current ATC documents for the young people living in the programs. The following table displays an example of the naming convention for both standard documents and ATC.

Document Type	Convention Example	Corresponding Date
Positive Behaviour Support Plan Data Analysis Report Welcome Book Activity Planner Under 12 Approval	AS 2020-04-21 PBSP  AS 2020-04-21 DAR  AS 2020-04-21 WB AS 2020-04-21 AP AS 2020-04-21 U12RDA	Reflects that the BSRP document is 'live' on the 21 <sup>st</sup> April 2020. This is the date that the document is shared with external stakeholders.
Authority To Care Case Plan Placement Agreement	AS 2020-04-21 ATC exp. 2020-10-21 AS 2020-04-21 CP exp. 2021-10-21 AS 2020-04-21 PA exp. 2021-10-21	Reflects that the ATC is live on 21 <sup>st</sup> April, 2020 and valid until the 121 <sup>st</sup> April, 2021. This is the date that a new ATC must be supplied.

### Archiving Documents (Active and Inactive Function)

To ensure that the current documents are visible and reduce file clutter, out of date or past versions of documents, such as Positive Behaviour Support Plan/Safety Plan and Data Analysis Report (DAR), are made 'inactive' via the 'deactivate' function. This does not delete or remove the documents, but rather moves those documents into a parallel filing structure, which stores documents that are currently not in use. 'Inactive' documents can still be viewed and reactivated when needed.

To deactivate a document, select the deactivate icon () linked with the corresponding document. CTARS will prompt with a confirmation prompt before allowing the deactivation to complete. To view deactivated documents, select the [Inactive Documents](#) button, located in the top right-hand corner when accessing the Client Documents page. After viewing inactive

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documents, select the [Active Documents](#) button, located in the top right-hand corner when accessing the Client Documents page, to return to active documents. As both active and inactive document filing structures are identical in layout, it is important to ensure the correct structure is accessed.

To support auditing and correct record management procedure, ensure that all out of date and past documents are moved to inactive and only current/in date documents are displayed in the Client Document structure. The exception to this is Incident Report correspondence which should be deactivated immediately at the time of upload.

### **Unit Data Entry Function**

The Unit Date Entry function holds all documentation relevant to the individual Units. This function includes the below CTARS Forms for completion:

- Emergency and Fire Safety
- Handover Checklist
- House Meeting Minutes
- Initial Referral Register
- MC Team Meeting minutes
- Unit Self-Assessment
- SOC Register
- Unit Information

The above CTARS forms are to be completed as outlined in the relevant RCaTS Procedures on the MercyNet Portal.

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## 4. Therapeutic Care Planning

### Therapeutic Assessment Report (TAR)

The Therapeutic Assessment Report (TAR) provides an overarching current assessment for the person we support. This structure allows individual progress through the four (4) phases of the *FS PP RCaTS RES Phased Trauma Recovery Model for Out of Home Care* to be identified and monitored, with a specific focus on the milestones, goals, and evolving support requirements unique to each individual person we support. The TAR is designed to be viewed by the Department and used to support Care Team members orientation and induction into the program and the people we support.

The TAR is designed to be reviewed at six (6) monthly intervals by the Clinical Team and utilises a variety of clinical data to inform the care planning process, such as profile and formulation information, evidence-based assessment tools, engagement and trauma recovery progress and departmental identified goals.

The TAR form is in the [Client Data Entry](#) navigation bar, under TAR ([Therapeutic Assessment Report](#)). An initial TAR form is created within the first four (4) weeks of the person we support's entry into the program and a new TAR form is created every six (6) months, or where a significant change has occurred to the therapeutic goals. As with all CTARS forms, to activate a new form a person we support's name must be selected at the top of the form. The form will automatically select the current date as the [Entry Date](#) and will select and display the appropriate [Hierarchy](#) for the person we support. The [Entry Date](#) refers to 'data entry data' and indicates the date the report was created. The hierarchy displayed should be the one associated with the person we support's current residential placement.

### Overview

This section outlines the overarching purpose of this document to provide context to the stakeholders receiving the document. This includes the below overview of the document structure:

- The 'Young Person Profile Summary' section includes current/live summary information for the person we support across key areas;
- The 'Phased Trauma Recovery Program' section includes an overview of the Phased Trauma Recovery Model and allows CTL's to indicate the current phase of recovery for the person we support;
- The 'Departmental Identified Goals' section outlines the key areas of focus that have been identified by Child Safety. These are displayed as in line with the Queensland Out-of-Home Care Outcomes Framework;
- The 'Assessment Outcome and Intervention Recommendations' section provides an overview of the assessment outcomes and the recommended interventions. These are displayed as in line with the Queensland Out-of-Home Care Outcomes Framework, with additional sections to identify target behaviour and phase progression for the coming reporting period; and
- The 'Approvals', section relates to Transition Plans and Appendix A should be completed where transition plans are relevant.

At the bottom of this first section of the TAR, the CTL is required to enter the following information into the required fields:

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Field Name	Information/Detail
Placement Commencement Date	This is the date that the person we support entered the placement with MC. This date remains the same for all TAR reviews.
Plan Date	This is the date that the current TAR becomes 'live'.
Plan Review Date	This is the projected date that the current TAR will be reviewed by. This date will be six (6) months from the <a href="#">Plan Date</a> .
Contributors to Plan	A list of the people who have contributed to the information and decision making within the document. This will include relevant MC Care Team members and stakeholders.

### Young Person Profile Summary

This section of the TAR is focused on providing a summary of the current and/or live person we support information across key areas. This part of the TAR is also covered during the Formulation process and information can be shared from the Formulation, if current. This section is completed with updated/current information at every review. The aim of this section is to provide a short summary/narrative context of the key current areas of the person we support's situation. This may include three (3) to five (5) dot points in each text field section.

#### 1. Diagnosis/Current Assessment

Include information regarding physical health, mental health, current diagnosis or current assessment, and current medication/treatment.

#### 2. History

Include relevant placement history, such as length of time with MC, last placement, and a brief summary of the Child Protection history.

#### 3. Family Context

Include current family contact, quality of family interaction, and recent or planned family contact changes.

#### 4. Social and Community Context

Include relevant cultural/community connection, and a summary of their ability to engage in a pro-social nature with the local community, peers, and organised groups.

#### 5. Competence and Capacity Context

Include current displayed level of age-appropriate living skills, emotional competence, and capacity to manage safety and positive interactions with others.

### Phased Trauma Recovery Program

This section provides an outline of the *FS PP RCaTS RES Phased Trauma Recovery Model for Out of Home Care* with proposed timelines, of the focus of each phase and goals.

At the bottom of this section is a drop-down field to record the [Young Person's Current Recovery Phase](#). This drop-down field allows long-term mapping to display the person we support's progression through the Trauma Recovery Model. The CTL will select the phase that the person we support is currently in. For the first TAR, this will generally be [Foundation](#), and it is expected to change and progress with the following six (6) monthly reviews.

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### **Departmental Identified Goals**

This section of the TAR provides information regarding the goals that have been identified and priorities for the coming six (6) months, as set by the Department. These goals are generally found in the person we support's referral information and/or the current Departmental Case Plan. Information for this section may also be collected during stakeholder or placement meetings. If information is collected during stakeholder or placement meetings, it is important to ensure those present are included as contributors to the TAR document.

Departmental goals are recorded under the corresponding QLD Out-of-Home Care Outcomes Framework domains, which is selected via a dropdown list. Selecting a domain from the dropdown box will activate a corresponding notes section, in which the corresponding Departmental goals are to be listed. To add multiple domains, select the [+Add another record](#) button. Ensure to add a separate entry for each domain and group the related critical items under the corresponding domain.

### **Assessment Outcomes and Intervention Recommendations**

Within this section there are six (6) text fields to record the intervention recommendations. This is structured to align with the Queensland Out-of-Home Care Outcomes Framework Domains. The six domains are listed below with information regarding the specifics of each domain:

#### **1. Safe and Nurtured Intervention Recommendations**

*Children and young people feel cared for and nurtured in stable environments, safe from abuse, neglect, violence, and threat.*

Outcomes:

- Protected from abuse, neglect, and exposure to violence;
- Nurtured and cared for; and
- Living in stable and predictable environments.

Success Indicators – people we support will live in homes where:

- They are not being harmed and they are physically safe;
- Their material needs are met;
- They feel cared for, nurtured, and valued;
- Their dignity and rights are respected; and
- They lead a violence free life.

#### **2. Connect Intervention Recommendations**

*Children and young people feel a strong sense of identity and belonging, have stable and long-lasting relationships with family and friends, and are connected to culture and community.*

Outcomes:

- Positively connected to family, culture, and community; and
- Feel a sense of identity and belonging.

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Success Indicators – people we support will:

- Have quality relationships with family, friends, and other significant people;
- Know their life history and have a sense of identity;
- Feel connected and have a sense of cultural and spiritual belonging to their community; and
- Have opportunities to engage in social, cultural and community events and activities.

### **3. Achieving Intervention Recommendations**

*Children and young people learn and develop to their full potential.*

Outcomes:

- Attend and engage in education;
- Meeting developmental milestones;
- Engage in, and benefit from, recreational activities; and
- Developing independence and life skills.

Success Indicators – people we support:

- Are ready for school at entry age;
- Attend, and engage in schooling;
- Achieve national educational standards;
- Have age and developmentally appropriate life skills;
- Develop and progress personally, socially, and educationally; and
- Have career aspirations.

### **4. Healthy Intervention Recommendations**

*Children and young people make healthy lifestyle choices and access health care services.*

Outcomes:

- Physically healthy;
- Emotionally and mentally healthy; and
- Leading an active and healthy lifestyle.

Success Indicators – people we support have:

- Access services and treatment that meet their physical, dental, sexual, and mental health needs;
- Access services and treatment that meet needs related to a disability or their development;
- Experience improvements to their health and wellbeing;
- Do not misuse drugs and alcohol; and
- Learn to independently make healthy lifestyle choices.

### **5. Resilient Intervention Recommendations**

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*Children and young people have strong social and interpersonal skills and feel confident to pursue life goals and manage challenges.*

Outcomes:

- Feel confident and have social skills;
- Possess coping skills and an ability to manage adversity; and
- Display positive and appropriate behaviour.

Success Indicators – people we support will:

- Access services and treatment that meet their therapeutic needs;
- Have positive relationships and treat other people with respect;
- Pursue recreational and extra-curricular activities;
- Engage in decision-making about their lives;
- Contribute to and support the community and others;
- Engage in positive and law-abiding behaviour;
- Have confidence and are able to successfully deal with life challenges; and
- Have goals and feel optimistic about their future.

## **6. Legal Intervention Recommendations**

Outcomes:

- Reduced engagement with Youth Justice programs;
- Increased pro-social engagement; and
- Increased ability to understand and comply with laws.

Success Indicators – people we support:

- Minimal engagement with legal services; and
- Pro-social engagement with Police.

When developing the intervention recommendations, ensure to reflect on the contextual/narrative information included in the Young Person Profile Summary, and the identified Departmental goals. Generally, there are between one (1) and five (5) interventions listed in each domain depending on the individual situation of the person we support. It is, however, important to ensure there is at a minimum of one (1) intervention listed in each domain, as this is the overarching goal that will inform smaller more detailed interventions over the coming six (6) monthly review period. The interventions in each section should be dot pointed, provide enough information and context to ensure they can be clearly transferred into smaller goals and interventions by the CTL, and clearly state the stakeholder responsible for the intervention (such as MC, the Department, etc.).

### **Formulation Summary**

Formulation sessions are not a mandatory aspect of the TAR, however, are highly recommended for complex or challenging cases. The [Formulation Summary](#) provides a summary of the Formulation discussion and the overarching analysis of the projected plan around the person we support. This section is generally summarised into one or two paragraphs, which references the main themes identified during the Formulation discussion and main therapeutic approaches that

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have been discussed. If a Formulation has been completed for the person we support during the current reporting period, include the [Formulation Summary](#) information in this section of the TAR. However, if no Formulation was completed for the person we support during the review period, note that 'No Formulation was completed this review period'.

**Note:** Formulations are generally held for People we support approximately six (6) monthly. More complex cases can have formulation occurring at a monthly basis.

### ***Targeted Behaviours for Upcoming Quarter***

In this section, the CTL identifies the key behavioural categories that will form the focus of data analysis of the next six (6) months (via Charts and Dashboard Reports). There is no limit to the number of categories that can be selected, however, generally three (3) categories are identified. When selecting the target behaviours, the CTL should consider the most prevalent behaviours that they and the stakeholder group are most concerned with. The target behaviours are not all challenging behaviours, because it is important to identify positive target behaviours to focus on as well. The following list are the behavioural categories that can be selected from:

- Anti-social Behaviour;
- Communication;
- Emotional Issues;
- Engagement and Learning;
- Health;
- Living Skills;
- Overt Behaviour;
- Personal Care;
- Problem Solving;
- Pro-social Behaviour; and
- Thoughts.

The specific behaviours that are linked with each category are outlined in more detail in the Dashboard Reports section of this document.

### ***Targeted Behaviours for upcoming 6 months.***

At the bottom of this section is a drop-down selection box is to indicate the projected phase that the person we support will either be in, or transition to, during the next six (6) months. People we support may remain in the same phase, progress to the next phase or re-visit the previous phase depending on their individual situation. This is often discussed and confirmed during the Formulation meeting. For more information on the Phased Trauma Recovery Model, refer to the *FS PP RCaTS RES Phased Trauma Recovery Model for Out-of-Home Care*.

### ***Appendix A: Transition Plans***

A key aspect of out-of-home care is that people we support experience moves and transitions. This can include both planned and emergency transitions, along with placement and service support transitions. People we support engage in a number of developmental transitions, such as transitioning to adulthood, planning and supports around these developmental milestones is critical and important to include in the overarching assessment and recommendation. This section

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is likely to be applicable to all people we support at different times and should be considered as a critical planning aspect.

### Completed By

This is the final section of the TAR, which holds the name and signature of the CTL who prepared the document, and the name and signature of the SPM who has reviewed and approved the document.

Once approved by the SPM, the TAR is published, and a PDF is shared with all relevant stakeholders. As the TAR is a form within CTARS, once published it can be accessed and exported as a PDF at any time. Due to this, there is no requirement to have PDF versions of the TAR in the Client Document section of CTARS. However, it is recommended to share the TAR with MC Care Team members to support their understanding of the longer-term goals and assessment outcomes. Refer to the Document Function section of this paper for the correct naming convention.

### Positive Behaviour Support Plans and Safety Plans

There are two (2) distinct safety plan and crisis management documents/functions available to the CTLs to ensure Positive Behaviour Support and Safety Planning occurs for the people we support. Refer to *FS PROC RCaTS Positive Behaviour Support* for further information about these documents.

### Saving and Sharing a Positive Behaviour Support Plan and Safety Plan

The *FS FORM RCaTS Positive Behaviour Support Plan* and *FS FORM RCaTS Safety Plan* are saved in the [Client Documents](#) tab in the navigation bar of the related person we support's file. Within the person we support's file, the *Positive Behaviour Support Plan* is to be saved under [Assessment and Intervention](#), then [Positive Behaviour Support Plans](#). The *Safety Plan* can be found under [Assessment and Intervention](#), then [Safety Plans](#).

On endorsing the *Safety Plan*, the SPM will convert the final documents to PDF and upload the PDF version within the [Client Documents](#) tab in CTARS. Refer to the Client Documents section for information on naming conversions and filing structure.

All *Positive Behaviour Support Plans* and *Safety Plans* will be reviewed when completing monthly reporting and sharing with the Department, alongside other monthly reporting documents. When sharing *Safety Plans*, ensure the document is fully completed, signed, and saved as a PDF.

### Benchmark Report

The Benchmark Report within CTARS collects data across several key forms and domains within the CTARS system and compares this data with individualised benchmark values. The Benchmark Report provides the reader with a quantitative understanding of how close the person we support is to their 'benchmark' or goal. Data is collected from forms and logs completed within the system (e.g., Activity Logs, Behaviour Logs, Incident Logs, Shift Reports, and the Client Profile) and mapped over a distinct time periods, displaying presentation at time of entry, the 'best' result and the previous time period. The Benchmark Report is best created on a monthly basis to display the

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previous month's data. The Benchmark Report is designed and structured to provide a clear summary of the type of engagement and progress that has been observed.

### ***Generating the Benchmark Report***

The Benchmark Report is located in the [Reports](#) navigation bar under [Benchmark Report](#). Within this section, a list of all generated reports will appear. To search for reports relating to a particular person we support, use the search bar at the top of the page. When generating a Benchmark Report, it is important to ensure that only one report is produced per person we support, per month. Once a Benchmark report has been generated for a particular month this report can be reviewed and updated without needing to generate an additional report for the same time period. Additionally, by having one report per month, per person we support, this minimises any chance of double up or duplicated work.

To generate a new Benchmark Report, select the [Add Report](#) button in the top right-hand corner of the Benchmark Report page. This will display a report generation page. On this page, select the person we support's name from the drop-down [Client](#) list and enter the date of the previous month in the [Date From](#) field. This date should be the first day of the previous month (for example, if this report is the February report, the [Date From](#) should be the 1<sup>st</sup> January). The [Date To](#) field should have the current month date (for example, if the report is the February report, the [Date To](#) should be the 1<sup>st</sup> February). Once the person we support's name, [Date From](#) and [Date To](#) has been entered, select the [Generate Report](#) button to request the report from the system.

### ***Reviewing the Benchmark Report***

Once generated, the system will display the Benchmark Report with all current data. CTLs are then able to engage in a review of this data and information from the past month. When reviewing the data, some changes and updates may need to be made. This may include updated Benchmark Goals, correcting organisational information or correcting an Activity Log entry. Once the Benchmark Report has been generated, it is possible to leave the Report, make corrections in other sections of CTARS and return to the same Report and 're-fresh' the data to display the updated values and information.

In this review, there are several key areas to check and review. These include:

- Ensuring the information sections at the top of the Report (sections include Report, Demographic, Placement Data and Organisation Data) have the correct information. This information is pulled from the Client Profile, and if incorrect, should be corrected in the Client Profile as soon as practicable.
- Reviewing the Benchmark Goal and Goal Achieved sections to ensure the correct benchmark values have been entered, and the contextual information is correct. If this information needs to be updated, this can be done in the [Benchmark](#) section of the Client Profile. It is vital to update this information at this point and then return to the Benchmark Report after updating.
- Reviewing the Activity Log entries, which will appear throughout the entire Report in the corresponding sections. Activity Logs will pull the narrative text entered and display this next to the date of the activity. Data from the type of Activity Logs will be displayed in 'This Period' section, corresponding with the Benchmark Goal. If there is an error in the Activity

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Log, this can be updated by locating the entry in the [Activity Log](#) section in the [Client Data Entry](#) navigation bar.

At the bottom of the Benchmark Report, there are three (3) save and update options, each with different purposes:

- [Save Comment](#)

This button enables the saving of commentary in the Summary Comment sections (outlined further in the next section of this paper). This should be clicked after adding any commentary to the Report.

- [Update Benchmark Values](#)

This button requests the report to update the Benchmark Values that are pulled into the Report. This is used to refresh the data after reviewing the Report.

- [Update Data Entry](#)

This button requests the Report to update data entry information, such as Activity Logs, Behaviour Logs, or Incident Reports. This is used to refresh the data after reviewing the Report.

### [Benchmark Report Summary Commentary](#)

At the bottom of the Benchmark Report, there is a section for commentary. This section provides a space for the CTL to summarise and provide clinical analysis on the data collected before finalising the report. The Summary section also allows the attachment of images/weblinks to deepen the context of the person we support's experience and engagement during the reporting period. This section is generally divided into several sub-headings, which are manually entered as the commentary is completed. These sub-headings are:

- Safe and Nurtured
  - Commentary on *Routine Benchmarks* section, *Respite Sections*; and
  - Outline any changes to *Goal Plans* due to analysis.
- Connected
  - Commentary on *Family, Guardian and Significant Others* section, *Legal/ Government Appointments* section; and
  - Outline any changes to *Goal Plans* due to analysis.
- Achieving
  - Commentary on *Educational/Vocational* section, *Living and Social Skills* section; and
  - Outline any changes to *Goal Plans* due to analysis.
- Healthy
  - Commentary on *Healthcare* section, *Medical Appointments* section; and
  - Outline any changes to *Goal Plans* due to analysis.
- Resilient
  - Commentary on *Therapy Sessions and Reference Person Meetings* section, *Behavioural Observations Data* section; and
  - Outline any changes to *Goal Plans* due to analysis.

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- Images
  - Insert any photos, artworks or certificates that are relevant to the reporting period and the progress of the person we support.

## *Saving of Benchmark Reports*

Once a Benchmark Report is generated, it will remain within that particular section of CTARS and does not need to be saved in any other location. A PDF version of the Report can be generated when required.

## **Dashboard Report**

The Dashboard Report is one way to view a detailed analysis of the many specific behavioural indicators that contribute to larger behavioural categories. The Dashboard Report pulls observed data from the Behavioural Logs completed by the Care Team and categorises the aligned/linked behaviours under broader behavioural banners the pulls from observed/collected data.

## *Behavioural Categories*

There are a number of Behavioural Categories that can be selected for the report, such as Thoughts, Prosocial Behaviour, Problem Solving, Personal Care, Overt Behaviour, Living Skills, Engagement and Learning, Emotional Issues, Antisocial Behaviour, Communication and Health. Each of these Behavioural Categories filter a number of more specific observable behaviours that are linked in each category. These are listed in the table below.

Behaviour Category	Observable Behaviours
Antisocial Behaviour	<ul style="list-style-type: none"> <li>• Antisocial Behaviour</li> <li>• Impulsive Behaviour Targeting Property of Others</li> <li>• Oppositional/Defiant Behaviour</li> <li>• Physical Aggression</li> <li>• Problems with Peers/Staff/Family</li> <li>• Refusal of Access</li> </ul>
Communication	<ul style="list-style-type: none"> <li>• Communication Issues</li> <li>• Problems with Peers/Staff/Family</li> <li>• Verbal Aggression</li> <li>• Withdrawal from Others</li> <li>• Active Listening</li> <li>• Conflict Management</li> <li>• Effective Communication</li> <li>• Listening</li> <li>• Politeness and Manners</li> <li>• Positive Interactions</li> <li>• Praising Others and Refraining from Negative Comments</li> </ul>
Emotional Issues	<ul style="list-style-type: none"> <li>• Anxiety</li> <li>• Binging/Purging/Refusal to Eat</li> <li>• Difficulty Regulating Emotions</li> <li>• Distress/Worry/Crying</li> </ul>

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Behaviour Category	Observable Behaviours
	<ul style="list-style-type: none"> <li>• Indiscriminate Disclosures</li> <li>• Obsessions or Compulsions</li> <li>• Overactive Behaviour</li> <li>• Self-criticism</li> <li>• Self-injury (evidence of)</li> <li>• Self-injury (thoughts of)</li> <li>• Sexualised Behaviour</li> <li>• Anger Management</li> </ul>
Engagement and Learning	<ul style="list-style-type: none"> <li>• Difficulties With/Refusal to Engage in Learning</li> <li>• Difficulties With/Refusal to Engage Independence Skills</li> <li>• Inattention/Lack of Concentration</li> <li>• Loss of Interest in Activities</li> <li>• Withdrawal from Others</li> <li>• Following Directions</li> <li>• Participation</li> <li>• Patience</li> <li>• Recognising/Understanding Points of View of Others</li> <li>• Remaining on Task</li> <li>• Taking Turns</li> </ul>
Health	<ul style="list-style-type: none"> <li>• Alcohol/Substance/Solvent Use</li> <li>• Binging/Purging/Refusal to Eat</li> <li>• Difficulties With/Refusal to Maintain Personal Care</li> <li>• Sleep Problems/Chronic Fatigue/Bed Wetting</li> <li>• Somatising</li> </ul>
Living Skills	<ul style="list-style-type: none"> <li>• Difficulties With/Refusal to Engage Independence Skills</li> <li>• Refusal of Access</li> <li>• Being Safe</li> <li>• Patience</li> <li>• Shows Initiative</li> </ul>
Overt Behaviour	<ul style="list-style-type: none"> <li>• Impulsive Behaviour Targeting Property of Others</li> <li>• Indiscriminate Disclosures</li> <li>• Mimicking Others Behaviour</li> <li>• Obsessions or Compulsions</li> <li>• Odd and/or Bizarre Behaviour</li> <li>• Oppositional/Defiant Behaviour</li> <li>• Physical Aggression</li> <li>• Sexualised Behaviour</li> </ul>
Personal Care	<ul style="list-style-type: none"> <li>• Alcohol/Substance/Solvent Use</li> <li>• Binging/Purging/Refusal to Eat</li> <li>• Difficulties With/Refusal to Maintain Personal Care</li> <li>• Sleep Problems/Chronic Fatigue/Bed Wetting</li> <li>• Verbal Aggression</li> <li>• Refusal of Access</li> <li>• Being Safe</li> </ul>

Behaviour Category	Observable Behaviours
	<ul style="list-style-type: none"> <li>Peer Resistance Skills</li> </ul>
Problem Solving	<ul style="list-style-type: none"> <li>Communication Issues</li> <li>Conflict Management</li> <li>Cooperation</li> <li>Recognising/Understanding Points of View of Others</li> <li>Social Problem Solving</li> </ul>
Prosocial Behaviour	<ul style="list-style-type: none"> <li>Being Respectful</li> <li>Cooperation</li> <li>Helping Others</li> <li>Increased Acceptance and Tolerance of Diverse Groups</li> <li>Patience</li> <li>Peer Resistance Skills</li> <li>Politeness and Manners</li> <li>Positive Interactions</li> <li>Praising Others and Refraining from Negative Comments</li> <li>Sharing</li> <li>Taking Turns</li> </ul>
Thoughts	<ul style="list-style-type: none"> <li>Abnormal Perceptions</li> <li>Distortion/Memory Loss</li> <li>Distress/Worry/Crying</li> <li>Fears and Phobias</li> <li>Inattention/Lack of Concentration</li> <li>Overactive Behaviour</li> <li>Self-Criticism</li> <li>Signs of/Disclosures of Hearing Voices</li> <li>Somatising</li> <li>Peer Resistance Skills</li> </ul>

### Generating the Dashboard Report

The Dashboard Report is located in the [Reports](#) navigation bar under [Dashboard Report](#). Within this section the list of all generated reports will appear. To search for a particular person we support's reports, use the search bar at the top of the page. The Dashboard Report does not produce a PDF report, but rather provides visual representatives of observed behaviour, each report can be changed and altered as needed. To minimise duplicated data, it is important to only produce one (1) report per person we support. This single report can be opened and edited to show different date ranges or include different combinations of behavioural categories.

To generate a new Dashboard Report, select the [New](#) button in the top right-hand corner of the Dashboard Report page, this will then display a report generation page. On this page select the person we support's name from the drop-down [Client](#) list and enter the required date range in the [Start Date](#) and [End Date](#) fields. Enter the nominated Target Behaviour into the [Select Categories](#) field (see below section on Categories for further information). Once the person we support's name, Start Date, End Date and Categories have been entered, select the [Generate Report](#) button to request the report from the system.

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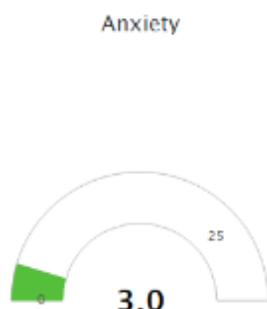
### Categories

It is acknowledged that displaying all data is not the most effective way to understand specific needs and provide clear analysis. To support clear and purposeful data analysis, a number of target categories are identified in the TAR document every six (6) months. It is these target categories that are generally displayed in the Dashboard Report. The target categories have been chosen due to their projected relevance to the person we support and their progression. However, if, due to behaviour changes, other categories becoming relevant, they can be included in the Dashboard Report at the discretion of the CTL.


### Understanding the Dashboard Report

The Dashboard Report displays data in visual way to show the frequency and prevalence of a particular behaviour. For every 'Yes' that is entered into one of the many [Data Entry Logs](#) within CTARS, this Report will pull that information and display it under to correct behaviour description and category. When reviewing the Dashboard Report, the visual 'dials' under each title show how often the behaviour was present over the reporting period. The more the dial is coloured, the more that behaviour was present. The large font number beneath the dial represents the total recorded occurrences of the behaviour, while the small font number within the dial represents the number of times this behaviour 'could' have been observed within the reporting period.

For example, a person we support's Dashboard Report showed the below visual:



This dial indicates that the person we support was observed to experience anxiety three (3) times out of the possible twenty five (25) observations.

Each of the dials can be individually displayed or printed by selecting the  icon next to the dial.

### Incident Analysis

The Dashboard Report provides graphing of the different levels and frequencies of incidents over the selected date range. This graph supports analysis of the changing nature of challenging or high-risk behaviours that the person we support has displayed. This information is used to provide analysis and support hypotheses of impacting factors on the person we support's behavioural changes.

### Dashboard Report Commentary

The Dashboard Report has the ability to hold commentary at the bottom of the report, however, this commentary section cannot currently be exported or linked with the visuals displayed. This commentary section can be saved for internal MC use; however, any comments will be lost when

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the report is refreshed. Although the commentary function of the report is not for external use, the data displayed may be shared with external stakeholders and it is important that any shared data is accompanied by commentary to provide context. In these cases, commentary is generally displayed under several sub-headings. These sub-headings are:

- Behavioural Presentation
  - Summary commentary of the presentation of the person we support, linking the collected narrative of the person we support's personality/engagement/goals and the observed behavioural data displayed in the report.
- Behavioural Trend Comparison
  - Commentary on the increasing or decreasing trajectory of observed behaviours;
  - Commentary on the type and frequency of incidents that have occurred and any links to displayed behaviours; and
  - Summary commentary on the overarching view of positive development or experience of challenges.
- Key Impacting Factors
  - Commentary on contextual information that is relevant to behavioural/incident data, such as increased/decreased family contact, school holidays, change in co-tenant, etc.

At the bottom of the Dashboard Report is a [Save](#) button, this will save commentary only until the report is refreshed.

### **[Saving and Sharing Dashboard Report Data](#)**

To save or share a report that holds information from the Dashboard Report, use the *FS TEMP RCaTS Data Analysis Report* on the MercyNet within the RCaTS Policies and Procedures page. This template provides a simple report template to display relevant data graphs and/or images and the relating analysis. More information on the *Data Analysis Report* can be found further on in this document.

## **Charts**


The charting function is located in the [Reports](#) navigation bar under [Charts](#). This report allows a detailed look at the trends displayed within a behavioural category. This function is used to visually display a wide range of data from behaviour trends to incident trends and interventions provided. The charting function is highly adaptable and the type of information available and this section will continue to develop.

### **[Generating Charts](#)**

To generate a chart, three (3) filters must be selected. The person we support's name must be selected from the drop-down [Client](#) list, a [Category](#) must be selected, and a date range option must be chosen ([Select Option](#)). Depending on the date range option, other date range options become visible, such as year and month. Once all filters are entered, click the [Generate Chart](#) button.

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### Understanding Charts

Once a chart has been generated, it displays a line graph with several levels of data layered on top of each other to show trends and changes in the person we support's presentation. As this display can become confusing with many layers, the layers can be hidden (and redisplayed) by clicking on the key at the bottom of the graph. The chart can be exported by selecting the  icon on the right-hand side of the graph.

Charts are a key tool in displaying data and providing a format that visually supports in-depth analysis of trends and overlapping behaviours. This tool can be used internally to support assessment, understanding the needs of the person we support, impacts of intervention, and supports long-term analysis. In relation to external reporting, the charting function will provide most (if not all) of the graphs required to complete the DAR, which is provided to the relevant stakeholders on a regular basis. More information on the DAR can be found further on in this paper.

### Saving of Charts

Charts can be generated for any period, as needed, with no requirement to save the PDF version of the Charts. However, if Charts have been used to create a wider analysis, including commentary, and have been submitted or provided to stakeholders (internal or external to MC) as a DAR, this Report would be saved within the Document section of CTARS. This would be within the person we support's individual file, under [Assessment and Intervention](#), then [Reports](#). Refer to the section on DAR's for further details.

## Goal Planning

The Goal Planning tool is used to proactively work towards positive outcomes for the person we support. Goal Planning can be, at times, viewed via a narrow field, such as only around setting goals to save money or achieve a task. However, Goal Planning in the context of Therapeutic Programming becomes wider and all inclusive. It is important to view Goal Planning from a framework perspective of 'what is the final/chosen positive outcome for the person we support in this area?'. In this way, Goal Planning can be applied to several clinical and operational areas, and automatically supports a positive outcome-driven perspective when developing and progressing therapeutic programming for a person we support.

### Setting Goals

Goals are set within each person we support's [Client Profile](#), in the [Goals](#) tab. It is within the [Goals](#) section of the [Client Profile](#) that the CTL identifies and sets the therapeutic goals for the person we support.

When developing Goals for a person we support, the CTL will refer to the TAR document (specifically the Assessment Outcome and Intervention Recommendations section to ensure the goals set are aligned with the overarching plan to support the person we support over the coming six (6) months. Alongside the information from the TAR, CTLs may also refer to the Departmental Referral, Stakeholder Meeting Minutes, and the person we support's personal views and wishes to set goals that respond to unique needs of the person we support.

The following tables provide information and direction to support entering Goals.

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CTARS Field Name	Type of information for Field	Information Category
My Goals	Select the <a href="#">Add Goal</a> button within the My Goals section to add a new goal. Please complete all sections and save.	Mandatory Information
Goal Title	<p>The Goal Title aims to provide a brief description of the purpose of the goal. This title should be written with a positive view of growth, development, building and not from a reductive view of reducing or removing.</p> <p>To support evidencing alignment with the Queensland Out-of-Home Care Outcomes Framework, it is important to add which domain the goal is linked with. For example, a goal focused on supporting the person we support to follow a healthy meal planner may be named 'Increase Health Eating Choices – Healthy'. This provides a clear focus of the goal and links this with the Queensland Out-of-Home Care Outcomes Framework domain of 'Healthy'. Another example may be a goal focused on emotional regulation. This goal could be named 'Increase Emotional Modulation Skills – Resilient'.</p>	Mandatory Information
Goal Details	<p>This section allows for text to describe the aims of the goal, and to outline how this is to be achieved. When setting the goal, the CTL will provide detail on how they would like the Care Team to work toward achieving this Goal with the person we support. Below are examples of the type of information that would be included.</p> <ul style="list-style-type: none"> <li>• <b>Goal = Increase Emotional Modulation Skills – Resilient</b> <ul style="list-style-type: none"> <li>○ The person we support currently has very little skills in emotional modulation (emotional modulation is the ability to manage and control the physical feeling of different emotions within their body). Due to this, when the person we support feels big emotions or experiences a quick change in emotion, they become more distressed as they feel out of control (emotionally and may even feel out of control physically). This is a very important skill to master to help build emotional intelligence and the ability to safely manage distress.</li> <li>○ There are activities and games on the person we support's planner to help with building this skill. These include</li> </ul> </li> </ul>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	<p>basketball for thirty (30) minutes then coming inside to have quiet time, then helping with cooking for dinner (person we support becomes very excited when cooking as it is one of their favoured activities). It is important to support the person we support to follow their planner so they can practice managing their excitement and energy levels.</p> <ul style="list-style-type: none"> <li>○ Throughout the day, if the person we support begins to present as becoming heightened or emotionally out of control, support them by naming what you are seeing, "It looks like you might be starting to feel a bit overwhelmed. Let's plan this together." Support them to use their Go To Plan, talk about the feeling or use sensory items. If they manage this successfully (without physical aggression) praise their great work and link with getting more points on the GBI for no aggression.</li> <li>○ Refer to Positive Behaviour Support Plan/Safety Plan as person we support can hit, kick or bite adults when feeling out of control.</li> </ul>	
Start Date	Set this date as the day the Goal has been added to the person we support's Client Profile.	Mandatory Information
Planned Achievement Date	This date is flexible, it can be a set date that the goal will be completed (may be a court date or end of school term goal).	Mandatory Information
Review Date	This is the date of the review of the goal, generally this is completed monthly, along with the Monthly Reporting process.	Mandatory Information

### Progress Update

Each Goal is, ideally, reviewed at the Team Meeting on a fortnightly basis, monthly as a minimum as per *FS PROC RCaTS Support and Intervention*. During the Team Meeting, the CTL leads the group through current Goals and a discussion on current progress, challenges, and alternate strategies. From this discussion the CTL completes a monthly Progress Update that provides an update on the Goals progress and assessment of risk and achievement. The Progress Update also feeds information into the Goals Report. The Progress Update has several sections, all of which are linked with Goal Status, the person we support's engagement, feedback from the person we support, and the risk assessment and progress of the goal.

The following tables provide information and direction to support entry of progress updates.

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CTARS Field Name	Type of information for Field	Information Category
Add Progress Update	Within the <a href="#">My Goals</a> section, every Goal entered for the person we support is displayed. This can be filtered by six (6) options at the top of the section. These are <a href="#">In Progress</a> , <a href="#">On Hold</a> , <a href="#">Achieved</a> , <a href="#">Not Achieved</a> , <a href="#">All</a> and <a href="#">Inactive</a> . These statuses are set and updated at each Progress Update. To add a Progress Update, select the <a href="#">Add Progress Update</a> icon next to the appropriate Goal. Complete all sections and save.	Mandatory Information
Goal Status	Select the appropriate <a href="#">Goal Status</a> from the drop-down box. The options are <a href="#">In Progress</a> , <a href="#">Achieved</a> , <a href="#">Not Achieved</a> or <a href="#">On Hold</a> .	Mandatory Information
Date of Progress Update	This is the date in which the Progress Update is being completed.	Mandatory Information
Client Engagement – Scale	As a group, discuss the level of engagement from the person we support in the Goal. This may be linked with compliance/attendance and displayed willingness to achieve the goal (even if they are finding it hard to complete). Select the level of engagement from 1-10 depending on the discussion and observed information.	Mandatory Information
Client Feedback	In the Client Feedback text box, add any comments the person we support has made relating to the goal. It is important to support the Care Team members to ask the people we support their thoughts on the goal to ensure that this section is meaningful.	Mandatory Information
Risk Assessment	In this section the CTL provides an assessment of the level of risk that is presenting. Here, it is important to note that there may be two (2) types of risk that could be referenced in this assessment. One being the risk that the Goal will not be achieved and, two, the physical/safety risk that the person we support or workers may be in due to not achieving the Goal. Both options are relevant and can be used when completing this section. However, to ensure clarity, the use of the <a href="#">Risk Narrative</a> text box is critical to provide context of the risk rating. Select the level of risk that is present (low/medium/high) from the drop-down box.	Mandatory Information
Risk Narrative	The <a href="#">Risk Narrative</a> text box is designed to provide context to the risk rating. <ul style="list-style-type: none"> <li>This may include information about the risk of a Goal not being achieved. For example,</li> </ul>	Mandatory Information

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CTARS Field Name	Type of information for Field	Information Category
	<p>discussion that continued school absence will result in cancelation of Centrelink Payments, or continued disengagement with Youth Justice will result in additional court appearances.</p> <ul style="list-style-type: none"> <li>This may include information for the Care Team to reduce safety risks and strategies to keep themselves and the person we support safe. For example, referencing their Positive Behaviour Support Plan/Safety Plan, outlining key scripting or redirection strategies that should be used, or when to call Police/report as a Missing Person.</li> </ul>	
Progress to Goal Achievement	The CTL leads comments on the level the goal has been achieved. It is acknowledged that this is a subjective decision, however, it is important to use objective markers as much as possible, such as the percentage of points that the person we support has earned towards their GBI, or number of required appointments/sessions to complete a course. Select the level of achievement from 1 to 10 depending on the discussion and observed information.	Mandatory Information
Progress Summary	Add contextual information regarding the level of ratings that have been given. This section can also hold any additional information and instructions for Care Team members.	Mandatory Information

### Goals Report/Goals Progress Report

The Goals Report provides a PDF document that displays information regarding the set goals for each person we support and the Progress Update information. The Goals Report will be produced after every team meeting and provided to the Care Team as a summary of the meeting's discussions and information for the next coming fortnight.

#### Generating the Goals Report

The [Goals Report](#) is located in the [Reports](#) section of the navigation bar. To generate the report, a person we support's name must be selected from the [Select Client](#) drop-down box. The status type of the Goals that are required for the report is selected from the [Goals Status](#) drop-down box. This report can be filtered by a date range or solely by the goal status. If a date range is required, ensure to tick the [Filter Goals by Date Range](#) box and to enter the [Start Date](#) and [End Date](#) of the required date range. Finally, choose from [Goals with Progress Updates](#) or [Goals Only](#) for the type of report produced. The standard uses for this report are as follows:

#### Fortnightly Team Meeting

This report provides the Care Team with up-to-date information on the current goals that they should focus on for the next fortnight for the person they are supporting. This also provides new

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Care Team members or those that have been away, with a point of reference for an update on the current person we support engagement, risks, and progress.

Filters/settings to produce Fortnightly Team Meeting Goals Report:

- One Report produced for each person we support in the house;
- Goals Status set to 'In Progress';
- Do not filter goals by date range; and
- Select Goals with Progress Updates for the Report Type field.

### *Stakeholder Meeting (monthly) and Monthly Department Reporting*

This Report is used to support the CTL to provide a clear update to the wider stakeholder group during the stakeholder meeting. This allows the stakeholder group to engage in conversation and decision making around challenges that may be preventing goal achievements/outcomes and is a clear way to share risks and understand the person we support's perspective.

Filters/settings to produce Stakeholder Meeting Goals Report:

- Produce one Report for the relevant person we support;
- Goals Status – this can be set on several statuses and will depend on each individual person we support's situation. In most cases, setting the Status to 'In Progress' will be relevant, however, it may be important to show the 'Achieved' Goals to show case positive outcomes or the 'On Hold/Not Achieved' goals for decision making;
- Generally, do not filter by date, however, if there are many Goals this may be useful; and
- Select Goals with Progress Updates for the Report Type field to allow information sharing around progress, risks, and the person we support's view.

### ***Saving of a Goals Report***

When a Goals Report is generated, CTARS will produce and download in a PDF, which is then provided to the appropriate group. There is no sign off or endorsement required for this Report as it is generated directly from CTARS. Refer to the Document Function section of this paper for the correct naming conventions. As this Report pulls data from within the system, there is no requirement to save the PDF version of the report. However, if using the Report for alternate funding (NDIS) or to evidence specific outcomes, the Goals Progress Report would be saved within the Documents section of CTARS, under the relevant person we support's file in [Assessment and Intervention](#), then [Reports](#).

### **Data Analysis Report (DAR)**

The *FS TEMP RCaTS Data Analysis Report* on the MercyNet Portal in the RCaTS Policy and Procedures section. This Microsoft Word document is used to present any data, graph and/or chart that has been generated via CTARS and is being presented. The template provides a clear report structure, uniformity of MC reporting and ensures the data is accompanied with commentary to provide context to the data. This report template can be used for both internal and external reporting.

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### Generating the Data Analysis Report

To generate a *DAR*, access the *FS TEMP RCaTS Data Analysis Report* on the MercyNet Portal. It is important to ensure that the most current version of the template is being used. As this report is outside of CTARS the person we support's information (name, date of birth and unit name) is not automatically generated and must be entered into the top section of the report. Ensure that this information is correct before sending the Report.

Within the body of the report there are three (3) standard sections to display graphs/charts.

1. *Incident Type Graph*

This graph can be displayed as a line or pie graph. This graph provides a visual representation of the type/category of incidents that have been reported.

2. *Incident Frequency Graph*

This graph is displayed as a line graph. This graph provides a visual representation of when incidents have occurred, how frequent and any time or context trends.

3. *Additional Identified Graph – Title*

This section provides a space to include graph/charts that show specific information for a person we support. This may be information that has been proactively requested by the Department, such as police attendance, night out of placement, bed wetting behaviour, etc. This section can be displayed as a line or pie graph, depending on the type of data. It is important to ensure that this section is given a title, to ensure clarity on the data presented. If required, this section can be repeated to include other specific information.

### Data Analysis Report Commentary

This section of the report is critical to supporting the reader to understand the meaning of the displayed graphs/charts. In this section of the Report, the CTL is able to provide critical analysis, deeper understanding of trends and presenting behaviour, draw links between several aspects of the person we support's experience and indicate progression or regression. Within the report template, this section provides a space of free text, however, depending on the data displayed, several sub-heads are recommended.

#### *Dashboard Report Data*

If using Dashboard Report data, the commentary would be focused around presenting behaviour and behaviour trends. This data is centred around observed behaviour and interactions. Commentary subheading would be structured as follows:

- Behavioural Presentation
  - Summary commentary of the presentation of the person we support, linking the collected narrative of the person we support's personality/engagement/goals and the observed behavioural data displayed in the report.
- Behavioural Trend Comparison
  - Commentary on the increasing or decreasing trajectory of observed behaviours;
  - Commentary on the frequency and type of incidents that have occurred and any links to displayed behaviours; and
  - Summary commentary on the overarching view of positive development or experience of challenges.

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- Key Impacting Factors
  - Commentary on contextual information that is relevant to behavioural/incident data, such as increased/decreased family contact, school holidays, change in co-tenant, etc.

#### *Charts Data*

If using Charts data, the commentary would be focused around presenting behaviour and behaviour trends and/or key/target engagements (such as Police involvement). Similar to the Dashboard Report, Charts present behavioural data and key observations/engagements. Commentary on this type of data would follow a similar subheading structure as Dashboard Reports (Behavioural Presentation, Behaviour Trend Comparison and Key Impacting Factors).

#### *Benchmark Report Data*

If using Benchmark Report data, the commentary would be around comparing and contrasting the entry values, set Benchmark Goals and the recorded outcome. This may include previous period data and best displayed data. This data is centred around achieving set goals that align with the QLD Out-of-Home Care Outcomes Framework, therefore commentary is high linked with goal achievement and/or capacity growth. Commentary subheadings may include:

- QLD Out-of-Home Care Outcomes Framework Domains:
  - Safe and Nurtured;
  - Connected;
  - Achieving;
  - Healthy; and
  - Resilient;
- Entry Capacity and Ability Growth;
- Key Challenges for Capacity Growth; and
- Changes in Goals/Focus.

#### *Ad hoc Report Data*

If using data from an Adhoc Report, the commentary would include:

- Purpose of the targeted behavioural reporting (possible information about where the data/observations have been pulled from, such as a uniquely designed form for the person we support or pre-set forms);
- Contextual information description what the data/graph/chart displays; and
- Commentary on the meaning/impact this data can/has provided for the improved care of the person we support.

It is highly recommended that any data produced from Adhoc Reports is always accompanied by commentary providing contextual information.

#### ***Saving and Sharing the Data Analysis Report***

At completion, the CTL signs off as the person preparing the Report. If the Report is being provided to external stakeholders or at a wider MC organisation level, the relevant SPM reviews the Report and provides the final approval signature. Once approved, the Report is saved as a PDF by the

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SPM within the [Clients Documents](#), [Assessment and Intervention](#), [Reports](#) section of CTARS, following the standard naming convention (as noted in this Paper).

Incident Reports are designed to capture critical information linked with the person we support's behaviour, experiences, and high-risk engagements. All Incident Reports for people we support are completed within the CTARS [Incident Log](#), located within the [Client Data Entry](#) section of the navigation panel. Once an Incident Log is completed and published, it will become visible within the [Incident Register](#) located in the main navigation panel. There are distinct different purposes between the [Incident Log](#) and the [Incident Register](#).

The [Incident Log](#) should be thought of as *the place data is managed*. This includes entering new data (a new incident log), adding extra information (a current log in draft) or deactivating data (a duplicated log or information that does not need reporting criteria).

In contrast, the [Incident Register](#) should be thought of as *the place where the response to the incident is managed*. There are several levels and type of responses that can occur for an incident, all are actioned within the [Incident Register](#). These responses and actions are outlined below in the Incident Reporting, and Incident Processing and Incident Register sections.

### Incident Reporting

Majority of [Incident Logs](#) are created by RCWs who were present during the incident, however, an Incident Log can also be completed by any level of leadership. Although an Incident Log collects a larger range of information, in its simplest form it is a factual record of an event that has been deemed a concern regarding the safety and well-being of a person we support within MC's care. For information regarding how to complete an [Incident Log](#) within the [Client Data Entry](#) and general incident reporting procedures, refer to the following supporting documents, which can be located on the MercyNet Portal:

- FS PROC RCaTS Incident Reporting;
- FS WF RCaTS Incident Reporting Process;
- FS IP RCaTS Incident Category Definitions – RCaTS;
- FS IP RCaTS Incident Management Learning Guide;
- FS PROC RCaTS Employee Standards of Care Matters; and
- FS IP RCaTS Managing Disclosures.

### Incident Processing and Incident Register

Once [Incident Logs](#) have been completed and published, they will appear in the [Incident Register](#) located in the navigation bar within CTARS. This register holds all 'processing' of incidents and the recording of the management and responses to the incident that occurred. It is important to note that while the [Incident Log](#) appears in the [Incident Register](#), the original log still remains in the [Incident Log](#) within [Client Data Entry](#).

The [Incident Register](#) is divided into two (2) main categories, [Open](#) and [Closed](#). When entering the [Incident Register](#), the page automatically opens to the [Open](#) incidents, as these currently

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require action and commentary. The option to view the [Closed](#) incidents is found on the top left-hand side above the list of incidents.

### Open Incidents

This page displays the [Incident Logs](#) that have been published and are requiring the CTL to add their commentary, analysis, and actions, and then for the SPM or RD to review and close the incident. The incidents that are [Open](#) are in a critical moment. Not only is this the point that CTLs review and develop a response, but this processing and 'closing' has the Department's reporting timeframes that must be complied with. For more information on timeframes, refer to the *FS PROC RCaTS Incident Reporting* and *FS WF RCaTS Incident Reporting Process*.

The main page within the [Open](#) section of the [Incident Register](#) displays all [Open](#) incidents, listed from the incident that has been open the most number of days at the top to the incident that has been open the least amount of days at the bottom. This is critical information as it provides information on compliance with the Department's reporting timeframes. There are several filters at the top of the page to support locating the incident reports that each role is required to process. The incidents can be filtered by:

- Client's names;
- Date range;
- Region or Unit; and
- Level of incident.

### Incident Report Processing – Stage One

CTLs are the first role to interact with an incident within the Incident Register, it is suggested to filter the register via either Client or Region/Unit to ensure all incidents are captured.

Action	Description and Actions	Therapeutic Considerations	Role Responsible
Accessing the Incident	To enter an incident log to begin processing, select the 'Edit' option under the <a href="#">Actions</a> for the relevant incident.	N/A	All who access the register
Review the Incident Information	Read through the information that has been recorded in the Incident Log. If during the review, an error is identified the following actions can be completed: <i>Critical information is incorrect or missing:</i> <ul style="list-style-type: none"> <li>• CTLs/SPMs can revert the Incident Log. This will require correcting to information in draft and re-publishing. It is important that these critical changes occur before processing continues.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure that the incident report has been completed correctly and all required information has been entered.</li> <li>• Aim to understand the events of the incident.</li> <li>• Aim to understand the Antecedent, Behaviour, De-escalation, Consequences and</li> </ul>	All who access the register.

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Action	Description and Actions	Therapeutic Considerations	Role Responsible
	<p><i>Non-critical information is incorrect or missing:</i></p> <ul style="list-style-type: none"> <li>Make note of the error and ensure to clearly correct or add the informing within the Immediate Intervention section.</li> </ul> <p><i>Duplicated entry:</i></p> <ul style="list-style-type: none"> <li>Locate the reference number of the original report.</li> <li>Note in the Actions, Investigation &amp; Comments section that this is a duplicated report, note the reference number of the original report and request for the SPM to deactivate the report on closure.</li> </ul> <p><i>Incident does not meet reporting criteria:</i></p> <ul style="list-style-type: none"> <li>Continue to process, however make recommendation that the report is deactivated by SPM on closure, due to not meeting reporting criteria</li> </ul>	<p>Possible Function of the incident.</p> <ul style="list-style-type: none"> <li>Ensure the correct incident categories have been identified.</li> <li>Ensure the incident has been correctly Rated (Medium, High, Critical).</li> <li>Review if any Physical interventions were applied.</li> <li>Review if any Legal Interventions were applied.</li> <li>Review Follow Up requests.</li> <li>Review if any PRN was offered or administered.</li> <li>Review Reporting to Manager/On-call information.</li> </ul>	
Review Resolution	At the top of the incident a red banner appears indicating the incident has not been closed. In this section is an option to click the <a href="#">Review Resolution</a> link. This makes a quick scroll action down to the first commentary section to process the incident report.	<ul style="list-style-type: none"> <li>This aims to save time when returning to an incident to continue processing.</li> <li>The whole incident should be read at each stage of processing.</li> </ul>	All who access the register
Immediate Intervention	This section is for the CTL to provide therapeutic insight into the events of the incident. This section should provide the reader of the report a clear understanding around the deeper/internal function of the behaviour/presentation. This section should also place the incident in the wider context of the person we support's experience and critical relationships, such as CSO, family, peers, co-tenants.	<ul style="list-style-type: none"> <li>Is this behaviour/ presentation known or a new behaviour?</li> <li>Did the Care Team follow the current therapeutic plans in place to respond to the presenting behaviour?</li> <li>Did the interventions work successfully?</li> <li>Has there been any new learning from this incident?</li> </ul>	CTL

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Action	Description and Actions	Therapeutic Considerations	Role Responsible
		<ul style="list-style-type: none"> <li>Will the interventions in place need to change, and why?</li> <li>Is the incident an indication of progression or regression?</li> <li>Comment on relationship repair and co-tenant dynamic if relevant.</li> </ul>	
Actions, Investigations and Comments	<p>This section is to record the concrete actions/tasks that will be completed in response to the incident. To add an Action, click on the <a href="#">+ Add Note</a> button, this will bring up a separate box to add the text into. The system will automatically record the name of the person entering the note and the date and time it was entered.</p> <p>Add a new note for each different action or comment. Include who is responsible for the action e.g., Care Team, CTL, or Child Safety etc.</p> <p>It is in this section that the request to deactivate an Incident Log is listed.</p>	<p>Ensure the following aspects are covered off if required,</p> <ul style="list-style-type: none"> <li>Response to property damage/need to replace items.</li> <li>Debriefing with the people we support (include who and when).</li> <li>Debriefing with the team members (include who and when).</li> <li>Clear changes to the intervention strategies (what and by when).</li> <li>Additional Care Team training that has been identified as required.</li> <li>Additional or different psychoeducation for the people we support.</li> <li>Review of other CTARS data, such as Behaviour Logs, Sleep Disturbance Logs, any Specialist Forms.</li> </ul>	CTL

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Action	Description and Actions	Therapeutic Considerations	Role Responsible
		<ul style="list-style-type: none"> <li>Informal and formal investigations that will take place as a result of the incident.</li> </ul>	
Incident Notification and Distribution	<p>This section is to record the reporting of the incident. This should include all verbal reporting and when the written report is shared, both during business hours and after hours.</p> <p>Add a new notification by clicking the <a href="#">+Add Incident Notification</a> button, this will bring up a separate box to add the text into.</p> <p><a href="#">Organisation/Governing Body Name</a> = Who the incident was reported to. This may be Child Safety After Hours, CSO, or Incident Report Distribution Group.</p> <p><a href="#">Notes</a> = Key information, such as if the reporting was verbal or via email and the names and roles of the people notified (e.g., CSO or TL etc.). For emailed incident report, list the names of the people provided the report within the same note.</p> <p><a href="#">Date Sent</a> = Record the date that the reporting was completed, either verbal or written.</p> <p><a href="#">Time Sent</a> = Record the time the reporting was completed, either verbal or written. Please select from the time slots provided.</p>	<ul style="list-style-type: none"> <li>Ensure that the information listed is clear and concise.</li> <li>Due to the critical nature of Incident Reporting timeframes, it is best practice to include as much information as possible.</li> <li>Provide details/rational in this section if the incident was reported outside of the expected timeframe. Examples may include: Workers needing to manage the safety of the people we support as a priority before completing the incident report, workers under reporting the incident and is being reviewed and moved to a higher category and therefore changing the reporting requirements, and/or human error and correct reporting process not being followed.</li> <li>Whether verbal reporting is required or not, it is best practice to add a notification in this section stating the decision and actions</li> </ul>	CTL/

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Action	Description and Actions	Therapeutic Considerations	Role Responsible
		around verbal reporting. If it is not required, for example, it could read <i>"The above incident was assessed as a Medium level incident, in which verbal reporting is completed at the discretion of the CTL, due to ..... verbal reporting was not deemed necessary."</i>	
Save	On completion of the Incident Notification and Distribution section, CTL is to click <a href="#">Save</a> , <b>not</b> <a href="#">Save and Close</a> .	This saves the current information and allows for SPM/RD to comment and close.	CTL

### **Incident Report Processing – Stage Two (final stage for most incidents)**

SPM/RD are the second roles to interact with an incident within the Incident Register, it is suggested to filter the register via either Client or Region/Unit to ensure all incidents are processed correctly.

Action	Description and Actions	Therapeutic Considerations	Role Responsible
Actions, Investigations and Comments	<p>As noted above, this section is to record the concrete actions/tasks that will be completed in response to the incident. To add an Action, click on the + Add Note button, this will bring up a separate box to add the text into. The system will automatically record the name of the person entering the note and the date and time it was entered.</p> <p>Add a new note for each different action or comment. Include who is responsible for the action e.g., Care Team, CTL, or Child Safety etc.</p>	<p>Ensure the following aspects are covered off if required:</p> <ul style="list-style-type: none"> <li>• Response to property damage/need to replace items.</li> <li>• Debriefing with the people we support (include who and when).</li> <li>• Debriefing with the team members (include who and when).</li> </ul>	SPM/RD

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Action	Description and Actions	Therapeutic Considerations	Role Responsible
	<p>SPMs will find requests to deactivate incidents in this section. If in agreement with the request to deactivate, SPMs make a note that they will deactivate the report.</p> <p>SPM may add additional actions, if required. This may include actions around Standard of Care matters or other investigation processes.</p>	<ul style="list-style-type: none"> <li>• Clear changes to the intervention strategies (what and by when).</li> <li>• Additional Care Team training that has been identified as required</li> <li>• Additional or different psychoeducation for the young people.</li> <li>• Review of other CTARS data, such as Behaviour Logs, Sleep Disturbance Logs, any Specialist Forms.</li> <li>• Informal and formal investigations that will take place as a result of the incident.</li> </ul>	
Incident Notification and Distribution	<p>As noted above this section is to record the reporting of the incident.</p> <p>SPM ensures this has been entered correctly and in timeframe. SPM may add extra notification if required as part of investigations or reviews.</p>	Ensure that the information listed is clear and concise.	SPM/RD
Incident Closure	This section is for any final comments regarding the closure of the incident. SPM to indicate if they have any additional comments on closing the incident.	N/A	SPM/RD
Save	On completion of the Incident Notification and Distribution section, SPM/RD is to click Save and Close. This will prompt the system to ask a confirmation question around closing the incident. It is critical to acknowledge that once an incident	N/A	SPM/RD

Action	Description and Actions	Therapeutic Considerations	Role Responsible
	is closed it cannot be reverted and edited.		

### Closed Incidents

Once incidents have been closed off by a SPM or RD, they can't be reverted or have any changes made to them. The incident log can however have additional comments added via the Amendments sections when viewing the report in the Closed tab. Although any incident can have an Amendment added, it is most likely to occur during a Standards of Care matter or as part of an internal investigation.

### Incident Report Progressing – Stage Three

All leadership roles are able to add Amendments to incident reports, however in the majority of cases this will be the responsibility of the SPM. The Amendments section enables information to be clearly recorded with the incident it is relating to. In addition, though the use of the Amendments section, larger organisational wide, reports such as HR and staff injury responses can be clearly exported and reported on.

Action	Description and Actions	Therapeutic Considerations	Role Responsible
Incident Amendments	This section is to support additional information or investigation outcomes to be clearly recorded with the incident report that is relevant. To add an Amendment, click on the + <a href="#">Add Amendment</a> button, this will bring up a separate box to add the text into. The system will automatically record the name of the person entering the note and the date and time it was entered.	<ul style="list-style-type: none"> <li>Details, actions, and outcome of SOC Discussion with the Department.</li> <li>If SOCR Process Investigation, include the actions and outcome of investigation. <ul style="list-style-type: none"> <li>Follow up as a result of the outcome.</li> <li>Any documents relating to Amendments are saved to S:Drive.</li> </ul> </li> </ul>	SPM/RD

### Incident Key Action Report

The Incident Key Action Report is a set Report located in the Reports navigation panel of CTARS. This report provides the ability to review multiple incident reports, including all comments, actions and amendments that have been added. This report can be used to review the responses to SOCR incidents and is used to support MC organisational wide reporting and Clinical Governance review.

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### Definitions

#### Care Team Leader

Employee tasked with client care planning and care management oversight within the MC-FYPS Residential Care and Transition Services Programs.

#### CTARS

A cloud-based client management system designed specifically for disability services, children's services, and aged care. The system will allow MC staff to undertake therapeutic planning and assessment, capture and report on outcomes and ensure practice complies with legislative requirements through industry best practice frameworks.

#### Regional Director

The manager with overall finance and program management responsibilities, who is a member of the leadership team.

#### Residential Care Worker

Employee tasked with providing daily care for young people.

#### Senior Program Manager

Employee tasked with day-to-day oversight of MC programs. The Senior Program Manager reports to the Regional Director.

### References

Aboriginal and Torres Strait Islander Placement Principles  
(<https://aifs.gov.au/cfca/publications/enhancing-implementation-aboriginal-and-torres-strait-islander-child/aboriginal-and#table1>)

CTARS Benchmark Report Guide ([www.support.ctars.com.au](http://www.support.ctars.com.au))

FS DOC RCaTS Program Overview

FS IP RCaTS CTARS Folder Structure

FS IP RCaTS Document Naming Conventions

FS IP RCaTS Incident Category Definitions

FS IP RCaTS Incident Management Learning Guide

FS IP RCaTS Managing Disclosures

FS PP RCaTS Proactive Strategies

FS PP RCaTS RES Phased Trauma Recovery Model within Out-of-Home Care

FS PP RCaTS Therapeutic Goal Based Incentives within Out-of-Home Care

FS PROC RCaTS Employee Standards of Care Matters

FS PROC RCaTS Health and Medication

FS PROC RCaTS Incident Reporting

FS PROC RCaTS Positive Behaviour Support

FS PROC RCaTS Records Management

FS PROC RCaTS Referral and Suitability Matching

FS PROC RCaTS Support and Intervention Planning

FS WF RCaTS Incident Reporting Process

### Related Documents

FS FORM RCaTS Positive Behaviour Support Plan

FS FORM RCaTS Safety Plan

FS TEMP RCaTS Data Analysis Report

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