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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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## Purpose

The central logic underpinning the intervention framework is that successful intervention in the lives of people we support with complex and challenging behaviours requires a multifaceted approach. One where the overriding emphasis is identifying needs, meeting needs, and responding sensitively to trauma; of providing safety and nurturing within a caring therapeutic milieu; where individual wellbeing and personal strengths are enhanced; and where focused support is provided for changing serious emotional and behavioural problems. It is within this multifaceted therapeutic environment that challenging behaviours can be managed through clearly established strategies and procedures covering conflict prevention, emergency management and appropriate corrective guidance and discipline.

The starting point for successful intervention is a thorough assessment of the person we support's needs. This includes an examination of their individual wellbeing, strengths, and areas where they require intensive support for identified serious emotional and behavioural problems.

## Scope

This procedure applies to all employees, volunteers and contractors engaged within Residential Care and Transition Services (RCaTS) programs across Mercy Community (MC) – Families and Young People Services (FYPS).

## Procedure

### 1. Support and intervention planning – overview

- 1.1 The support and intervention planning process forms part of the care management system, underpinned by several theoretical approaches outlined in the *FS PP RCaTS RES Phased Trauma Recovery Model for Out-of-home Care Settings*. This includes a needs-based, trauma-sensitive, and relationship/attachment-focused approach to residential care service provision.
- 1.2 Support and intervention planning is a holistic and cyclic process that commences as soon as a person we support's referral for placement is accepted. This process is also represented in the *FS WF RCaTS CTARS Care Planning* (Residential Care or Supported Independent Living Program SILP).
- 1.3 Support and intervention planning for people we support is guided by the following:
  - Client information as outlined within their CTARS Client Profile;
  - *CTARS Therapeutic Assessment Report (TAR)*;
  - *FS FORM RCaTS Positive Behaviour Support Plan* and *FS FORM RCaTS Safety Plan*;
  - Individual Planner; and
  - Identified Goals including Goal-Based Incentives.
- 1.4 While each of these plans/documents serves a different purpose, as outlined within the *FS PP RCaTS CTARS Therapeutic Programming Guide* and the *FS PROC RCaTS Positive Behaviour Support*, they should comprise a single, coherent assessment and action plan to support a person we support.
- 1.5 MC should not undertake support and intervention planning in isolation. MC assessments and plans should complement Case Plans developed by the

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Department of Child Safety, Seniors, and Disability Services (the Department) and other relevant assessments, to ensure that common goals are being achieved.

- 1.6 All components of intervention plans are consistent with standards set out in the *Child Protection Act 1999 (Qld)* and the Department's *Positive Behaviour Support Policy*. In alignment with this policy, the *CTARS TAR*, *FS FORM RCaTS Positive Behaviour Support Plan*, and *FS FORM RCaTS Safety Plan* must not include prohibited practices.
- 1.7 While responsibility for assessment and support planning processes is generally assumed by the CTL, all MC workers are responsible for being aware of support and intervention plans and ensuring that they are completing action items, as required.

## 2. Care planning – referral and suitability

- 2.1 Refer to *FS PROC RCaTS Referral and Suitability Matching* in the first instance.
- 2.2 In the instance of emergency referrals, it is essential that critical information within the CTARS Client Profile, such as basic demographics, alerts, allergies, non-contact details and medications, are recorded. Any required *FS FORM RCaTS Positive Behaviour Support Plan* and *FS FORM RCaTS Safety Plan* are to be developed and provided, with the referral information, to the care team prior to the person we support entering the placement. Additional forms and information, including Individual Planners, should be completed as soon as practicable following the entry of the person we support.

## 3. Care planning – transition and entry

- 3.1 Refer to *FS PROC RCaTS Entry and Induction* in the first instance.
- 3.2 During the transition and entry process, the information gathered is used to prepare the care team and program for the person we support's entry. A key part of the transition process is to support the safety within the program for current people we support, as well as the person we support entering the program.
- 3.3 The minimum information to be completed prior to entry includes:
  - Critical information to be entered in the person we support's CTARS Client Profile, such as medication and allergies;
  - *FS FORM RCaTS Positive Behaviour Support Plan* and *FS FORM RCaTS Safety Plan*;
  - Individual Planner and routine (see *FS PP Therapeutic Planning for Trauma Recovery and Resilience Building*); and
  - Visual Transition Plan outlining the activities planned to occur throughout the transition (e.g., development of a Go To Plan, MC care team meet and greet with cotenant, purchasing items for bedroom, move in date, etc.).

## 4. Care planning – assessment and intervention planning

- 4.1 MC engages in bio-psycho-social assessments to support the development of intervention planning. Assessments and plans should be informed by all available information. Where information is missing or may appear inaccurate, MC should attempt to clarify this wherever possible.
- 4.2 The people we support should be afforded the opportunity to engage and have input to goal planning. The CTL will support the people we support to complete a *FS FORM RCaTS My Future Goals (Under 12 Years or 12 Years and Over version*,

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whichever appropriate) within the first two (2) weeks of entry. The goal plan will be attached to the *CTARS TAR* and reviewed six (6) monthly in line with the *CTARS TAR*.

- 4.3 The information gained through bio-psycho-social assessment and the *FS FORM RCaTS My Future Goals* will assist informing the *CTARS TAR*.
- 4.4 In line with MC privacy provisions, individuals providing MC with information should be made aware of how the information will be used and, if required, how the information will be stored.
- 4.5 Sources of information informing assessments and plans include, but are not limited to:
  - The person we support's Referral Form;
  - Feedback from the Child Safety Officer (CSO);
  - Stakeholder meetings with the Department and other relevant stakeholders;
  - Departmental Case Plan;
  - Interviews with the person we support;
  - Interviews with previous carers;
  - Interviews with parents or guardians (if appropriate);
  - Interviews with any person or agency that may provide relevant information;
  - Existing MC information;
  - Key assessments or reports regarding the person we support; and
  - Departmental Child Health Passport.
- 4.6 **Therapeutic Assessment Report (TAR):**
  - 4.6.1 A *CTARS TAR* is developed by the Care Team Leader (CTL)/SILP Caseworker (SILP CW) for the express purpose of providing overarching assessment and proactive long-term intervention planning for people we support. A *CTARS TAR* must be developed within four (4) weeks of the person we support entering placement.
  - 4.6.2 A *CTARS TAR* is made up of the following components:
    - Brief Profile Summary – this outlines current context in key areas of the person we support's life experience, this section aligns with the *CTARS Client Profile* within the *Formulation* document;
    - Current and Projected Phase within the Phased Trauma Recovery Model – this aspect identifies the phase the person we support is currently in, and the project phase for the coming quarter;
    - Departmental Identified Goals – this is an overview of goals which have been outlined within the Departmental Case Plan;
    - Assessment Outcomes and Intervention Recommendations – this is reflective of the Outcomes and Indicators outlined in the *FS DOC RCaTS Program Overview*. These recommendations support the overarching long-term goals for the people we support, which are then broken down to smaller goals in the person we support's *FS FORM RCaTS Short-Term Goal Plan*; and
    - Identified Transition Plans (where assessed as required and approved).
  - 4.6.3 The CTL/SILP CW will review Departmental files, information provided by stakeholders, assessment tools, logs, Incident Reports, and any other

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relevant documentation to inform updates to the *CTARS TAR*. Where applicable, based on the person we support's age and capacity, a living skills assessment may also be appropriate to aid informing goals and intervention planning.

### 4.7 **Departmental Case File review:**

4.7.1 At times, it can be important to understand the person we support's history in planning interventions. This information can be gained through a Departmental Case File Review. A Departmental Case File Review will be dependent on the need for this information and the Department approval to release files. Where a file review can occur, it is best practice to occur in the first twelve (12) weeks of placement. The CTL will liaise with the person we support's CSO to commence this review. If the request for a Departmental Case File review is refused, the CTL may request specific information from the CSO or, alternatively, complete assessments based on the available information.

4.7.2 Where the CTL has been able to arrange a Departmental Case File review, this will be recorded on the *FS FORM RCaTS Departmental Case File Review*.

4.7.3 All correspondence pertaining to requests for Departmental Case File reviews must be uploaded to the person we support's CTARS Client Profile.

### 4.8 **Living skills assessment:**

4.8.1 The development of independent living skills is a vital goal of people we support who are approaching transition to adulthood, such as people we support in residential care who are fifteen (15) years and over and those within the SILP, ensuring that people we support develop sufficient skills and networks to succeed beyond their time in Departmental care. Continual assessment of a person we support's life skills should inform all support strategies and intervention plans. Guidance for this assessment is outlined in *FS IP RCaTS SILP Assessing and Reassessing Living Skills*.

4.8.2 Importantly, all MC workers must ensure that they observe the person we support's life skills and do not just rely on the person we support's self-report.

4.8.3 Workers must ensure that they work with people we support in a way that promotes self-agency and the development of independence. This includes collaborative and empowering approaches to problem solving and ensuring that support offered to people we support is sustainable. SILP CWs should consider themselves mentors to people we support and look for learning opportunities in common, everyday situations.

4.8.4 Living skills may be taught to people we support in formal and informal ways, including:

- Learning opportunities organised by MC workers;
- Programs delivered by external agencies; and
- Module-based living skill workbooks (delivered by SILP CWs). Refer to the 'Related Documents' section below for list of workbooks available.

### 4.9 **Intervention planning:**

4.9.1 MC takes a holistic approach to intervention planning, which relates to, and is directly informed by, the outcomes of, and need identified, through the completed assessments. Intervention planning occurs by exploring and developing a full range of objectives, goals (linked to the Child Safety

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Outcomes Framework) and actions that will support meeting the needs of people we support. This will support the development of a plan and clear actions that will increase person we support's strengths and capacity, reduce barriers and is objective and achievable within set timeframes.

- 4.9.2 Throughout the intervention planning process, both long and short-term goals are developed. Long-term goals are outlined in the *CTARS TAR* and short-term goals are outlined in the *FS FORM RCaTS Short-Term Goal Plan*.
- 4.9.3 The short-term goals should be directly related to the long-term goals. The actions and interventions are the treatments and services needed to meet the person we support's needs and goals.
- 4.9.4 Goal setting should include person we support, where possible. The person we support's feedback and input can be done so through the weekly Person Reference Meeting and the *FS FORM RCaTS My Future Goals*.
- 4.9.5 Intervention planning is captured within the *CTARS TAR*, *FS FORM RCaTS My Future Goals*, *FS FORM RCaTS Short-Term Goal Plan*, and through the *FS FORM Positive Behaviour Support Plan* and *FS FORM RCaTS Safety Plan*.
- 4.9.6 Cultural support planning should occur in line with the *FS PROC RCaTS Cultural Support Planning*. The *CTARS Cultural Support Plan* is to be completed within three (3) months of entry and reviewed three (3) monthly thereafter alongside the *CTARS TAR*.

## 5. Evaluation and review

- 5.1 Evaluation and review are important parts of the case management system and supports tracking progress towards the person we support's goals and/or barriers to implementation of goals. It also ensures that intervention strategies are being implemented and reviewed to meet changing needs and circumstances of clients.
- 5.2 Evaluation and review of goals occurs in both formal and informal documents, some with set timeframes and others in an 'as needed' manner.
- 5.3 Informal evaluations and reviews tend to be practice focused and based on individual exploration and peer discussions. For both behaviour support and case management goals can occur in the following settings and documents:
  - Adhoc reviews of CTARS data;
  - Peer discussions and consultations;
  - Individual review of behaviour change and skills growth/regression; and
  - Review and mapping of goals progression against expected outcomes.
- 5.4 Formal evaluation and review include monthly Departmental reporting, proactive internal consultation, and external consultation, such as:
  - Weekly Reference Person Meetings between the CTL and people we support to review the people we support's feedback. A *CTARS Activity Log* is to be recorded by the CTL for each Reference Person Meeting; if unable to attend, the CTL must complete a *CTARS Activity Log* noting this. Where the person we support is entering residential care for respite; however, do not hold a full-time placement, Reference Person Meetings can occur once (1) per month.
  - Monthly Incident Analysis and quarterly Emotional and Behavioural Data review (using *FS FORM RCaTS Short-Term Goal Plan*);

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- Monthly *FS FORM RCaTS Short-Term Goal Plan* reporting progress of current short-term goals;
- Monthly Stakeholder Meeting Minutes (minimum/desired six (6) weekly) recording stakeholder discussion and actions;
- Monthly *FS FORM RCaTS Positive Behaviour Support Plan* and *FS FORM RCaTS Safety Plan* reporting current Safety Plans for high/extreme risk behaviours/situations;
- Six (6) monthly *CTARS TAR* review, to review assessment of needs and projected long-term goals;
- Case Consultation with Senior Program Manager (SPM) to discuss current case challenges and plan actions; and
- Complex Case Discussion (include relevant MC care team and external stakeholders) to discuss shared understanding of current challenges, contributing factors and planning intervention from a holistic whole stakeholder group.

### 5.5 Critical reviews:

5.5.1 Outside of the above noted cycle reviews can be triggered by noted exceptions:

- Critical incidents: a person we support's involvement in a critical incident may highlight the need to review and update the current strategies to address the newly identified behaviours.
- Workers identify the need for a review: If a worker identifies the need for a review of any plan, this must be communicated to the CTL/SILP CW during the team meeting, via email, verbal feedback, or within Supervision. It is the responsibility of workers to state why they believe the review is needed and what changes they believe should be made. The CTL/SILP CW will undertake an assessment of the feedback to determine if changes are required and to which plan. If required, the CTL/SILP CW will update the plan within a reasonable timeframe depending on the context of the feedback provided and its priority to ensuring effective support and intervention practice.
- Where a critical issue/incident arises that necessitates an immediate change to the *CTARS TAR*, *FS FORM RCaTS Short-Term Goal Plan*, *FS FORM RCaTS Positive Behaviour Support Plan*, and/or *FS FORM RCaTS Safety Plan*, the CTL will record the intention to undertake a review, including timeframe for review, in the Actions, Investigations and Comments section on the critical Incident Log. They will then email all relevant workers with a summary of the changes and direct them to the updated document.

## 6. Care planning – transition and exit

- 6.1 Provide the current *FS FORM RCaTS Positive Behaviour Support Plan*, any relevant *FS FORM RCaTS Safety Plans*, and *FS FORM RCaTS Transfer of Medication to New Placement* (where required) that are in action as well as and produce and review *FS FORM RCaTS Short-Term Goal Plan* with all goals. Provide this document as a summary to the Department of all achieved and in progress goals.
- 6.2 Refer to *FS PROC RCaTS Transitions and Exits* for further information.

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### 7. Records management

- 7.1 Completed assessments and support plans will be documented within the person we support's CTARS Client Profile and a copy provided to the person we support's CSO. Where a document is updated, revised documents must be provided to the CSO as soon as practicable. Where there is a substantial change, the CTL may also wish to telephone the CSO to discuss the changes.

## Definitions

### Care Team Leader (CTL)

Employee tasked with care planning and management oversight for the people we support within MC RCaTS programs.

### Child Safety Officer (CSO)

An employee of the Department and delegate of the Chief Executive tasked with the statutory case management of young people subject to a Child Protection Order.

### CTARS

CTARS is 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.

### Departmental Case Plans

Statutory documents produced by the Department that govern statutory case management by the Department.

### Program Coordinator (PC)

The employee tasked with day-to-day program management responsibilities.

### Senior Program Manager (SPM)

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

### Senior Residential Care Worker (Senior RCW)

Employee tasked with the day-to-day support and coaching of MC workers and running of an MC RCaTS program.

### SILP Caseworker

Employees allocated case management or responsibility for people we support in the SILP.

### Worker

Residential Care Worker tasked with providing daily care for people we support.

## References

Department's Managing High Risk Behaviour Policy  
Department's Positive Behaviour Support Policy  
FS DOC RCaTS Program Overview  
FS IP RCaTS SILP Assessing and Reassessing Living Skills  
FS PP RCaTS CTARS Therapeutic Programming Guide  
FS PP RCaTS Proactive Strategies  
FS PP RCaTS RES Phased Trauma Recovery Model for Out-of-home Care Settings

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## References

FS PP Therapeutic Planning for Trauma Recovery and Resilience Building  
 FS PROC RCaTS Cultural Support Planning  
 FS PROC RCaTS Entry and Induction  
 FS PROC RCaTS Positive Behaviour Support  
 FS PROC RCaTS Referral and Suitability Matching  
 FS PROC RCaTS Transitions and Exits  
 FS WF RCaTS RES CTARS Care Planning  
 FS WF RCaTS SILP CTARS Care Planning

## Related Documents

### CTARS Documents:

CTARS Activity Log  
 CTARS Cultural Support Plan  
 CTARS Therapeutic Assessment Report

### MercyNet Documents:

FS DOC RCaTS SILP Handbook Education and Vocation  
 FS DOC RCaTS SILP Handbook Independent Living Skills  
 FS DOC RCaTS SILP Handbook Legal Matters  
 FS DOC RCaTS SILP Handbook Transition to Adulthood  
 FS FORM RCaTS Departmental Case File Review  
 FS FORM RCaTS My Future Goals (12 Years and Over)  
 FS FORM RCaTS My Future Goals (Under 12 Years)  
 FS FORM RCaTS Positive Behaviour Support Plan  
 FS FORM RCaTS Safety Plan  
 FS FORM RCaTS Short-Term Goal Plan  
 FS FORM RCaTS Transfer of Medication to New Placement  
 FS TEMP RCaTS Data Analysis Report

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