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## 1. Scope

The aim of proactive strategies is to engage in positive behaviour change and to minimise further traumatising experiences for the people we support within the placement. Proactive strategies are referenced in several care planning documents. This guide is designed to build target knowledge and for best practice reflection.

This document is used in two main ways, 1) to support carer program orientation and increase consistency across the carer responses and 2) to provide an index of resources to support positive and proactive behaviour management within a home-based environment.

## 2. Overview of Residential Care and Transition Services Proactive Strategies Implementation

This document holds a large number of proactive strategies, some of which are relevant to all Mercy Community (MC) residential care sites and some that are specific to individual needs or program designs. Key purposes of this document are to provide MC practitioners with standardised proactive strategies that promote positive behaviour support, promote safety, and align with current best-practice and Mercy Community (MC) values.

### Structure and Flexibility

The document information is structured via a table, displayed below.

Strategies	Description	Placement Status/Comment	Active in Placement
Name of the strategies	Description of the baseline strategies and approach	Space for placement specific information, often handwritten	Yes or no, depending on if the strategy is active in the placement

The proactive strategies have been grouped into three (3) categories. These categories look at proactive strategies from different perspectives and aspects of the wholistic therapeutic approach.

- House Set-Up*

These are strategies that relate to the physical environment of the house, such as set-up of particular rooms and items within each room.

- Program/Placement Design*

These are strategies that relate to the expectations and design of the placement, such as if the placement is supporting pre-adolescent children, a sibling group or young people close to transition to adulthood.

- Interaction Approaches*

These are strategies that refer to the type of proactive interactions required from the carer working with the person we support. This may be linked with building independence skills or the level and type of nurturing the people we support require.

Each proactive strategy has been developed to be generalised, in line with legislation, best practice and MC values. However, there may be situations where a different strategy is required, or the strategies need to be altered to best meet the needs of the people we support or the placement. In these cases, it is critical that the MC staff seek consultation with their line manager to reflect and assess the changing or unique needs of the person we support and/or family. Alterations to these strategies may also require consultation with external stakeholders, such as the Department of Child Safety, Seniors, and Disability Services (the Department), therapists and the NDIS Quality and Safeguards Commission.

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*Integration with Care Planning Documentation (RCaTS only)*

The main care planning location that proactive strategies can be found is within the person we support's goals, as recorded in CTARS. On some occasions proactive strategies may also be included in s Positive Behaviour Support Plans and Safety Planning. Finally, this document is located in each program and is used as a program specific reference via completing the tables found throughout the document. It is important to acknowledge that small changes to proactive strategies may occur frequently within the program, however the overarching concepts and theoretical underpinning remain the same.

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### 3. Proactive Strategies

#### House Set-up

Kitchen			
Strategies	Description	Program Status/Comment	Active in Program
Kitchenware – Standard	<p>The house standard is for kitchenware to be metal cutlery and crockery, including several pots, pans, and cooking trays. These items are kept in the kitchen and checked by the carers on a regular basis.</p> <p>If assessed as necessary to reduce risk and increase safety, plastic cutlery may be required, in this situation Child Safety must be involved in decision making and this should be recording in the Positive Behaviour Support Plan with a clear plan to move toward metal cutlery.</p>		<input type="checkbox"/>
Food Storage	<p>The aim is for all food items to be stored in the house kitchen. Most food items are kept in the main fridge and pantry in the kitchen. A few days' worth of meat is kept in the freeze in the kitchen. Due to storage needs and managing menu planning, some food may be kept in a second fridge in the office/pantry, or in the dry good's storage cupboards in the office/pantry. Examples of these items are bulk packets of school lunch items, bulk size containers of Milo, cordial, or ice-cream. There may be instances where the person we support's access to food creates imminent risk or actual harm to themselves or others. In these situations, food storage may need to be access limited until the risk reduces or to prevent ongoing actual harm. Some people we support may require different food storage arrangements to meet their assessed support needs, for example a medical condition or trauma-related behaviour. Any variation to food storage will be implemented in consultation with the Department and documented clearly in the Placement Agreement and Positive Behaviour Support Plan. Any variation will be reassessed regularly with a goal to move towards adherence for usual food access.</p>		<input type="checkbox"/>
Appliances	<p>The location of cooking appliances such as slow cookers, sandwich press, toaster, or blenders, should be assessed based on individual need and risk assessment. At times these are kept in the office or pantry, generally during the Foundation period (or during a transition of an incoming person we support). As the safety of the house is understood, all cooking appliances are moved into the kitchen.</p>		<input type="checkbox"/>

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Kitchen			
Strategies	Description	Program Status/Comment	Active in Program
	<p>The kitchen has a small container of dishwashing liquid and hand soap available for cleaning (larger bottles and other cleaning items/chemicals are kept in the Chemical Storage Cupboard – refer to Storage Strategies), alongside tea-towels and kitchen sponges. All household cleaners and chemicals are standard, organisation approved (RCaTS only) and child safe to maximise household safety. Kitchen fire safety items and instructions are displayed in the kitchen. Depending on the kitchen floor plan, Kitchens will have kitchen bench stools, and/or a table and chairs.</p> <p><b>Note:</b> <i>If there has been an incident and the environment has been managed to reduce risk, it is important that when the people we support return to baseline that the kitchen is reset. Relevant for RCaTS – during house reset/set-up photos are taken of the kitchen to support carers reset the house and replace items as needed.</i></p>		

Communal Spaces			
Strategies	Description	Program Status/Comment	Active in Program
Communal Spaces	<p>Communal spaces, such as lounge room, TV rooms and bathrooms are furnished with homely, comfortable furnishings, including couches, soft furnishings, wall artwork, tables/coffee tables, TV/gaming consoles and books/boardgames. These spaces are individualised to the needs of the people we support in the house and may include aspects such as TV protection covers or internal wiring to reduce risk and property damage.</p> <p>House Expectations are set with the people we support in the house that include rules and boundaries for communal spaces, such as sharing items and spaces, when TV/gaming consoles are used, and where books and games are stored. Carers help the people we support to set and maintain these expectations and ensure that all furniture and items are returned to the set configuration of the house communal spaces after each activity.</p>		<input type="checkbox"/>

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Communal Spaces			
Strategies	Description	Program Status/Comment	Active in Program
	<b>Note:</b> Relevant for RCaTS – during house reset/set-up photos are taken of communal spaces to support Care Team members re-set the house and replace items as needed.		

Staff Room/Office (RCaTS only)			
Strategies	Description	Program Status/Comment	Active in Program
Staff Room/Office	<p>Office space is for Care Team members only; people we support are not to enter the office. This is for consideration of safety and privacy as the office spaces contain items such as chemicals, sharps, keys, and confidential information. Confidentiality within placement is highly respected and a number of measures are taken to ensure that the people we support's confidentiality is respected at all times. These measures include:</p> <ul style="list-style-type: none"> <li>Care Team members will be provided with a key to the residence when they arrive on shift, and this must be returned prior to their departure. Care Team members are responsible for keeping these keys secure and on their person at all times. All keys must be locked in the internal and external lock boxes or safe when not in use.</li> <li>The office door will be always locked when not in use.</li> <li>The office storage room door will be kept locked at all times and between each use.</li> <li>Filing cabinets in the office will be stored behind a locked door and kept locked at all times and between each use.</li> <li>All confidential information, such as client folders, Unit Information folder, etc. are to be stored in the locked storage room within the office.</li> <li>No people we support are to have access to the office space, and this will be enforced by all Care Team members.</li> </ul> <p>Care Team members are responsible for all of their personal possessions and should leave any valuable items at home or in their vehicle, out of sight. Care</p>		<input type="checkbox"/>

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Staff Room/Office (RCaTS only)			
Strategies	Description	Program Status/Comment	Active in Program
	<p>Team members are to leave all non-essential personal items in the office and not have them out on the floor with people we support.</p> <p>Care Team members must lock their personal vehicle keys and valuable items, such as wallet, in the safe behind a locked door in the office.</p> <p>Where vehicle keys are in use, staff are required to keep secure carriage of their personal and program vehicle keys. Meaning, if staff have vehicle keys, they are required to keep these secured out of sight in a pocket (preferably buttoned/zipped), secured in a pouch belt/waist bag or securely attached to a belt via key clip or key carabiner. Vehicle keys are not to be carried on lanyards or other mechanisms that can easily break or detach. For vehicles with a keyless start feature, keys must be carried in a faraday pouch which blocks the electromagnetic signal. For further information, see <i>WHS SOP Transporting Clients</i>.</p>		

Medication and Chemical Storage			
Strategies	Description	Program Status/Comment	Active in Program
Medication	<p>All medication (prescription and over the counter) will be kept locked in the safe secured in the office. Except for SIL placements or planned support for people we support to begin managing their own medication, all medication will be administered by carers, as required, in accordance with medical practitioner or pharmacist directions. Please refer to <i>FS PROC RCaTS Health and Medication</i> for further information. Should any medication need to leave the house or go with a person we support on a sleepover please refer to the Medication Management Procedure for further information on how to manage this.</p> <p>CTARS Multifactor Authentication requires a code from a personal device to access CTARS to log medication. Workers will be required to take their personal phones with them when out of placement to support medication administration record keeping.</p>		<input type="checkbox"/>

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Medication and Chemical Storage			
Strategies	Description	Program Status/Comment	Active in Program
Chemical	All chemicals, aerosols and cleaning products are to be stored in the locked chemical storage cupboard and are not to be accessed by the people we support. People we support will not have access to heavy chemicals regardless of their age or level of supervision.		<input type="checkbox"/>

People We Support's Bedroom			
Strategies	Description	Program Status/Comment	Active in Program
People We Support's Bedrooms	<p>Each person we support's bedroom is their own personal space, and each bedroom can be locked from the inside so the people we support feel safe and secure in their own domain. On entry into the program, the person we support is supported to personalise their bedroom space, this may be through setting up their own personal belongings or planning to purchase new items. New people we support entering the program are supported to have new toiletries, such as toothpaste, shampoo, deodorant etc. The person we support's Care Team will help them to manage the number of belongings they have, to reduce excessive belongings that result in unhealthily clutter or development of harmful behaviour. To maintain safety and privacy, people we support are not to enter each other's rooms. This boundary is discussed with the people we support on entry and during House Expectations setting. It is acknowledged that in sibling group program, boundaries, and expectations of people we support entering each other's bedrooms will be re-assessed and aligned with person we support's safety and positive, normed sibling relationships.</p> <p>Care Team members will respect the privacy of each person we support at all times and will only enter a person we support's bedroom if they have been invited in or if there is potential risk of harm or the safety of the person we support or others may be at risk. People we support are supported to understand that if a carer suspects they have unsafe items, or items not in line with the House Expectations, carers can conduct a room search and remove these items. These</p>		<input type="checkbox"/>

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People We Support's Bedroom			
Strategies	Description	Program Status/Comment	Active in Program
	<p>items may include; drugs, alcohol, cigarettes, razors, aerosols, explicit images, DVD's or stolen property. All people we support are encouraged to keep important and personal items in their bedroom for safe keeping .</p> <p>In some cases, photographs will be taken of the person we support's room when it is tidy to assist the person we support to develop skills in cleaning their room. This is developed jointly with the person we support and the Care Team.</p> <p>At times people we support can have difficulties maintain a clean and hygienic bedroom; when this occurs, it is important that there are plans in place to support; this might include the Care Team going in daily to reset the bedroom.</p>		

Garage/Car Park			
Strategies	Description	Program Status/Comment	Active in Program
Garage/Car Park	<p>Program vehicles are to be locked and parked in the garage (if possible) when not in use, cars are to be always kept clean and tidy. All cars are to be re-fuelled before they go under a quarter in the tank.</p> <p>Program vehicle keys must be always locked in the safe behind a locked door in the office when not in use. For vehicles with keyless start, these must be stored within a faraday pouch to block electromagnetic signals.</p> <p>All Residential Care Worker (RCW) personal vehicles must be always locked, and any valuable items left in the vehicle must be placed out of sight. Personal vehicle keys must be kept in the safe behind a locked door in the office when not in use.</p> <p>Visitor vehicle keys e.g., keys in the possession of Community Visitors, departmental officers, family members, tradespeople etc. are considered vehicle keys that are in use, therefore vehicle keys are not required to be locked in the safe, however, it must be ensured that all visitors are made aware of and adhere to the requirements for the secure carriage of vehicle keys. Meaning, visitors are required to keep secure carriage of their vehicle keys; they are required to keep these secured out of sight in a pocket (preferably buttoned/zipped), secured in a</p>		<input type="checkbox"/>

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Garage/Car Park			
Strategies	Description	Program Status/Comment	Active in Program
	<p>pouch belt/waist bag or securely attached to a belt via key clip or key carabiner. Vehicle keys are not to be carried on lanyards or other mechanisms that can easily break or detach. All program vehicles have a fuel card. The fuel card is generally kept on the car's keyring, however, it may be stored in the program 'car pack' with other essential items. Please ensure you complete vehicle logbooks after each use of any MC vehicle. This is to include the date, time, kilometres. If a program vehicle is damaged in any way, an incident report must be filled out. People we support's personal bikes can be kept in the garage and access provided according to the planner or on request (depending on the level of risk assessed in the PBSP). Program garage is to remain locked when not in use (if applicable to the house).</p> <p><b>Note:</b> During House Re-Set/Set-Up photos are taken of the garage to support Care Team members re-set the house and replace items as needed.</p> <p><b>Where there is a risk of unsafe behaviour in a vehicle or risk of a person we support attempting to gain access to the car, a FS FORM RCaTS Safety Plan must be completed.</b></p>		

Backyard/Outdoor Spaces			
Strategies	Description	Program Status/Comment	Active in Program
Backyard/ Outdoor Spaces	<p>The backyard/outdoor space of the program includes items such as outdoor seating spaces, outdoor games, and equipment (trampoline if there is space) and items to engage with the garden (watering can/hose). The outdoor spaces are maintained by MC maintenance, however people we support are encouraged to grow plants and use these spaces for their individual likes.</p> <p><b>Note:</b> During a House Re-Set/Set-Up photo are taken of the outdoor spaces to support Care Team members re-set the space and replace items as needed.</p>		<input type="checkbox"/>

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<b>Additional Program-specific notes</b>

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*Program Design*

Routine and Scheduling Adherence			
Strategies	Description	Program Status/Comment	Active in Program
Planners	<p>Each program has a House Planner in the office, which outlines the general structure of the program's schedule. This House Planner is to be used to support the Care Team to understand the base expectations of the program and provide information on intentionality behind the program design.</p> <p>Each person we support in the program has a planner that is developed specifically for them to outline their activity and appointment schedule for that week. This is reflected as a weekly planner and a daily planner for each individual person we support in the program. The planner also encourages the people we support and the Care Team to engage in a therapeutic planned program to support positive outcomes. The person we support is involved in the development of their personalised planner when they have their weekly Reference Person Meeting with their Care Team Leader (CTL)/Clinician. The person we support's personalised planner is also aligned with the Trauma Recovery Phase that they are currently in and will reflect capacities such as ability to have independent time and engage in community events.</p>		<input type="checkbox"/>
Maintaining Scheduled Adherence	<p>At times the planned activity is unable to occur on the day, this may be due to external factors (weather) or the person we support's current presentation (illness, distress). At these times, the Care Team members help the person we support to engage in 'like-for-like' type decision-making to change the plan for the day. This is ideally done during the Daily Planning Meeting in the morning, so the person we support is prepared and aware of the change to their day.</p> <p>When the person we support is encountering a challenge or is distressed, they can find it hard to maintain the structure of their daily planner. This is a normal reaction and a time to help people we support to develop coping skills, emotional intelligence, and resilient responses. In these moments it is the goal of the Care Team to assist the person we support through their distress/crisis, referring to the individual Goal Plans, Positive Behaviour Support Plans and Safety Plans to direct their responses. When the crisis is over, it is the second goal of the Care Team to</p>		<input type="checkbox"/>

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Routine and Scheduling Adherence			
Strategies	Description	Program Status/Comment	Active in Program
	<p>assist the person we support to return to their planner and continue with the planned activities for the day.</p> <p>People we support will at times refuse to engage in a planned activity. It is important for the Care Team caring for the person we support to continue with the activity (if safe) and encourage the person we support to join them. It is key that the Care Team maintain the planner even if the person we support is disengaging or non-compliant.</p> <p>People we support can find following a structured planner very different from their past experiences. Care Team members are to have active and overt conversations with the people we support in the house around what is happening next on their planner, how much time they have until the activity changes and discuss what help they need to finish the current activity and move onto the next activity. This active prompting supports people we support to learn about the predictability of the planner and their placement, as well as supporting them to learn time management skills and build capacity to manage change.</p>		
Goal Based Incentives (GBIs)	<p>Every person we support has GBIs developed for them, these will fall under the categories of Planner Compliance and Prosocial/No Aggressive Behaviour. GBIs are a way to encourage and motivate people we support to engage in positive behaviours and support their positive engagement in routines and house expectations. Very similar to reward charts that many children experience in family homes, thereby providing normative experiences for the people we support. It is key for the Care Team to actively and overtly engage in discussion around how the person we support can achieve points towards their GBIs and support them to reflect on why they are doing a good job or finding it challenging to follow the GBI.</p>		<input type="checkbox"/>
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Planner and routines are structured and predictable.</li> <li>Focus on understanding the new program's structure, such as when House Meeting happens, when the CTL/Clinician visits.</li> </ul>		<input type="checkbox"/>

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Routine and Scheduling Adherence			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Focus on Care Team interactions and building positive and safe relationships with their new Care Team.</li> <li>Focus on connecting with the placement and feeling secure in the predictability of the plan and the Care Team around them.</li> <li>Providing clear and consistent house safety expectations.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Planner has added flexibility and choice around how the people we support would like to spend their time.</li> <li>High focus on building practical/life skill capacities, emotional capacity, and responsibility within the house such as cooking skills, community/group activities and increased chores (money earning) opportunity.</li> <li>Focus on using the Care Team as a secure base to feel confident to try new things and learn new skills.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Increased flexibility and choice around how they would like to spend their time, may include Independent Time (Departmental consultation required).</li> <li>Focus on targeted activities to highlight natural and chosen interests.</li> <li>Including Life Story work with CLT/Clinician.</li> <li>Focus on individual identity and personality development.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>May be the person we support creating their own planner in consultation with CTL/Clinician or the CTL/Clinician may be supporting a new placement (family/foster care) to understand their planner and make relevant for future placement.</li> <li>Focus on responsibility and growing skills to self-manage time and commitments (age appropriate).</li> <li>Focus on partnering with Care Team.</li> </ul>		

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Sleep and Wake-up Routine			
Strategies	Description	Program Status/Comment	Active in Program
Sleep and Wake Up Routine	People we support are supported to have a clear and predictable wake-up and bedtime, this is set to align with their age and individual needs (such as school attendance). People we support are provided with a visual (text/images) morning and bedtime routine to understand their daily routine and provide a predictable expectation. Care Team members and people we support are to have a copy of these routines.		<input type="checkbox"/>
General Morning Routine	<ul style="list-style-type: none"> <li>Have a clear wake-up time</li> <li>If the person we support wakes-up early, they have items (books, toys) to play with in their room until wake-up time</li> <li>Person we support is supported to have breakfast and take any medication. Engage in the Daily Planning Meeting over or after breakfast.</li> <li>Complete their hygiene routine and get dressed for the day.</li> <li>Tidy their room and gather any needed items for the day</li> </ul>		<input type="checkbox"/>
General Bedtime Routine	<ul style="list-style-type: none"> <li>Complete personal hygiene routine after dinner and get dressed for bed.</li> <li>Support the person we support to prepare the house for bedtime, turning off lights, turning down music/TV, engaging in calming activities (Care Team to complete if the person we support is unable to).</li> <li>Potential one-on-one time with a Care Team member. This time includes storytelling/reading and conversations about the plans for the morning and the following day. Explore processes linked to bedtime and wake-up if this part of the conversation is too challenging to begin with i.e., music signalling routine change, times breakfasts are available, 'do you prefer to be woken up by XXXX or XXXX?'</li> <li>Look at preferences that cue bedtime – pulling the sheets tight, turning a night light on, turning down other lights in the house, picking a story for story time, blankie, etc.</li> </ul>		<input type="checkbox"/>
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Often generalised and highly structured routines</li> <li>Level of individual assessment is engaged.</li> </ul>		<input type="checkbox"/>

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Sleep and Wake-up Routine			
Strategies	Description	Program Status/Comment	Active in Program
	<p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Routines becomes more unique and specialised to the person we support's individual likes and preferences.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Maintains predictable and known routines to provide a clear aspect of secure base during time of targeted interventions and Life Story work.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>Bedtime routines may be altered and changed to help the person we support to self-manage their routine or to be compatible with potential future placement (family/foster care).</li> </ul>		

Hygiene Management			
Strategies	Description	Program Status/Comment	Active in Program
Hygiene Management	<p>The person we support is supported to have all required/appropriate hygiene items when they enter the program. These are generally contained in individual cases and kept in the person we support's room. Some houses have shared toiletries (such as shampoo and conditioner) in the shower and may dispense toiletries in smaller portions to manage risk if these items are targeted during escalations. Toothbrushes kept in the bathroom must have individual holders. People we support are assisted to have a clear hygiene routine that they follow every day. This is to support the development of positive hygiene management and self-care. Care Team members may need to prompt people we support to have showers or complete their daily hygiene routine. If Care Team members notice a pattern or repeated hygiene issues, this needs to be brought to the immediate attention of the CLT/Clinician.</p>		<input type="checkbox"/>
General Hygiene	<ul style="list-style-type: none"> <li>How to and frequency of brushing teeth</li> <li>How to and frequency of having a bath/shower.</li> <li>Toilet use management.</li> </ul>		<input type="checkbox"/>

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Hygiene Management			
Strategies	Description	Program Status/Comment	Active in Program
Routine includes	<ul style="list-style-type: none"> <li>Period management/hygiene</li> <li>Body odour tools and frequency</li> <li>Clean clothing/washing, how to and frequency.</li> </ul>		
Bathroom	Care Team members facilitate people we support to utilise the bathroom without interruption from other residents. Both the bathroom and toilet lock from the inside so people we support feel safe and privacy is respected when accessing these facilities. House Expectations agreements help people we support to understand that only one person we support is to be in the bathroom at a time.		<input type="checkbox"/>
Hair Removal	With the exception of SIL placements, people we support who require access to razors must request them from the office and must return them immediately after use unless assessed by the CTL that it is appropriate for them to have these items themselves. When razors are assessed as unsafe for a person we support/ program, people we support are supported to use other methods of managing hair removal, such as hair removal creams. When safe to use, a 'shaving pack' is provided to the person we support, this pack is stored in the office and provided to the person we support upon request.		<input type="checkbox"/>
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Often generalised and highly structured routines</li> <li>Level of individual assessment is engaged.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Routines becomes more unique and specialised to the person we support's individual likes and preferences.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Maintains predictable and known routines to provide a clear aspect of secure base during time of targeted interventions and Life Story work.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p>		<input type="checkbox"/>

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Hygiene Management			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>This may be altered and changed to help the person we support to self-manage their hygiene or to be compatible with potential future placement (family/foster care)</li> </ul>		

Diet, Nutrition and Meal Management			
Strategies	Description	Program Status/Comment	Active in Program
Diet, Nutrition and Meal Management	People we support will be provided with access to nutritious foods which are identified at the House Meeting when developing the menu planner. Dietary requirements must be taken into consideration including the access to foods high in preservatives and sugar, particularly for very young children as this may impact their behaviour. If Care Team members recognise a person we support has an issue with food or there are concerns, this should immediately be brought to the attention of the CTL/Clinician.		<input type="checkbox"/>
Diet and Nutrition	<p>Every program has a unique menu plan that is set every week with Care Team members seeking active and overt engagement from the people we support in the program. This is set during the Weekly House Meeting. The menu plan is designed to include :</p> <ul style="list-style-type: none"> <li>Predictable take-out-night, once a fortnight</li> <li>Person we support preference and choice for at least one dinner per week (each person we support in the program has the opportunity to pick a favourite dinner to have)</li> <li>Weekly Special Dinner, such as Sunday roast dinner</li> <li>Appropriate and healthy school lunches</li> <li>Meals that the people we support can help cook and prepare</li> </ul>		<input type="checkbox"/>
Meal Management	<p>The following outlines general house management of mealtime and food.</p> <p>No food is to be taken into bedrooms, meals must be eaten in the communal areas and main meals eaten at the table.</p>		<input type="checkbox"/>

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Diet, Nutrition and Meal Management			
Strategies	Description	Program Status/Comment	Active in Program
	<p>Care Team members are to eat all meals with the people we support and engage in building healthy group dynamics around mealtime.</p> <p>Support positive mealtime rituals, such as setting the table for dinner (may include using a tablecloth, setting out cutlery or placemats).</p> <p>Care Team members are to proactively engage the people we support in mealtime conversations, such as their days experiences/plans, new things they have learnt, light-hearted jokes and storytelling.</p> <p>Care Team members are to assist people we support to develop polite table manners, such as eating with mouth closed, not talking with food in their mouth, using please and thank you, waiting for others to join the table to eat. This may be supported by visual aids and can be linked with GBIs of Pro-social behaviour.</p>		
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Focus on establishing routines and house expectations.</li> <li>Focus on understanding preferences and dietary requirements.</li> <li>Developing dynamic of sharing and accepting other people's preferences</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Focus on building skills to manage own healthy choices.</li> <li>Focus on personal (age appropriate) cooking and meal preparation skills.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Maintains predictable and known routines to provide a clear aspect of secure base during time of targeted interventions and Life Story work, they may include Care Team proactively identifying preferred meals or take-away to help the person we support to feel connected and understood.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>This may be altered and changed to assist the person we support to self-manage their food or to be compatible with potential future placement (family/foster care)</li> </ul>		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Chores/Pocket Money			
Strategies	Description	Program Status/Comment	Active in Program
General House Chores	<p>Within the program maintaining their own bedroom falls under their daily/general responsibilities. People we support are encouraged to clean their room on a daily basis, with changing bedsheets occurring once a week.</p> <p>There may be occasions where people we support refuse to do their chores or clean their rooms. In this circumstance it is important that the Care Team are maintaining the environment for them and providing support and prompting to re-engage. Care Team members are to inform the people we support that they need to clean their room within a certain timeframe or that the Care Team will be doing this for them.</p>		<input type="checkbox"/>
Chore Charts and Pocket Money	<p>Each person we support has a chore chart which enables them to earn pocket money. Each chore is linked with a dollar figure and added together once a week. Some chores are linked with greater dollar amounts depending on the challenge aspects of the chore. The total amount of money that a person we support can earn is set depending on their age, this is to match with social norms and expectations.</p> <p>People we support are able to withdraw or spend their pocket money when the daily planner specifies.</p>		<input type="checkbox"/>
Chore Types	<p>Depending on the person we support's age, capacity and ability to manage safety, different chores are set. This assessment is completed by the CTL/Clinician and the Care Team regularly at team meetings. The aim is to help the person we support to experience the success of earning pocket money, while supporting them to learn new life skills. Chores may include:</p> <ul style="list-style-type: none"> <li>• Cleaning the microwave</li> <li>• Watering the garden</li> <li>• Taking the bins out</li> <li>• Bringing the bins in</li> <li>• Cleaning the bathroom mirror and sink</li> <li>• Mopping the floor (could be room specific as builds skill, such as only kitchen or only hallway)</li> </ul>		<input type="checkbox"/>

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Chores/Pocket Money			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Putting own clothing in washing machine, hanging out own clothing on washing line/putting in dryer</li> <li>Doing the dishes</li> <li>Setting the table</li> <li>Washing the car</li> </ul>		
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Focus on small tasks to support motivation and routine ‘buy in’.</li> <li>Chores set to ensure safety and low risk situations.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Focus on building life skill capacity.</li> <li>Increase task variety and opportunity to learn</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Increased responsibility within the program</li> <li>Increased ability to select/negotiate chores.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>This may be altered and changed to help the person we support to self-manage their money or to be compatible with potential future placement (family/foster care) May need to develop/identify alternate income (Centrelink/work) if next placement is unable to provide financial support</li> </ul>		<input type="checkbox"/>

Savings Plan			
Strategies	Description	Program Status/Comment	Active in Program
Savings Plan	To develop positive and intentional financial management skills and knowledge, people we support can be supported to develop a long-term savings plan and goal. These goals are identified as too large to be earned via a GBI process and not within general costs for the person we support that are covered by MC. Examples		<input type="checkbox"/>

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Savings Plan			
Strategies	Description	Program Status/Comment	Active in Program
	<p>of these goals may be a computer, expensive shoes/clothing or an expensive bike/scooter.</p> <p>This plan is initiated by the CTL/Clinician and approval is given from Senior Program Manager (SPM).</p> <p>The person we support is required to be fully engaged in setting the Savings Plan Goal. Their engagement must include an ability to understand basic elements of saving (with room to develop), agree on a reasonable/achievable goal and sustain a long-term goal/motivation. Savings Plans may last a few months and are often set to align with the school year term, with the goal of achieving the goal by the school holidays. The dollar amount is agreed on by the SPM in line with funding agreements, in consultation with the CTL/Clinician. People we support would generally be expected to agree on an amount from their pocket money being added to their savings each week, and MC matching their contributions to go 'halves' in the savings goal.</p>		

Environmental Setting Conditions			
Strategies	Description	Program Status/Comment	Active in Program
General Environmental Settings	<p>To manage safety in the house, the Care Team will continue to engage in dynamic risk assessments of the physical environment with the aim of reducing any potential high-risk situations. This assessment should occur via a house walk through at the start of every shift and ongoing scanning of the environment. This will include identifying and removing items that will cause an immediate risk to the people we support or Care Team.</p> <p>Care Team members engage in proactive management of the house environment to reduce risk and increase the person we support's ability to manage challenging situations. This may include the following:</p> <ul style="list-style-type: none"> <li>Managing the temperature of the house</li> <li>Altering the lighting in the house</li> </ul>		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Environmental Setting Conditions			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>The use of music and quiet at different times, helping the people we support to use headphones to reduce impacts on other people we support.</li> <li>Maintaining a clean and ordered house and reducing clutter as a trigger or potential weapons.</li> <li>Reporting property damage as soon as possible to arrange for repairs.</li> </ul>		
Hot Spots	Due to the differing physical layout of the houses, it is critical for Care Team members to be aware of any particular places in the house that may be riskier than others during an escalation. In most houses, the office door, bedroom doors, bathroom door and hallways are places to be more aware of during an escalation/incident. These 'hot spots' are detailed in individual program orientation documents. Generally, it is important for Care Team members to be active in removing themselves from these areas during an escalation, this will reduce risk to the person we support and the Care Team, potentially result in de-escalating the situation and/or provide the person we support with sufficient space to self-regulate.		<input type="checkbox"/>
Sharps	All sharps, razors and scissors and large knives should be kept in the office locked in the safe or within office or pantry room. These items should only be provided to the people we support after it has been identified by the CTL/Clinician that they are not a risk, and it is part of their plan. These items will require a high level of supervision for people we support to access. Depending on the person we support's age, assessed level of stimulation or potential risk of self-harm, access may be restricted to Care Team members' use only. Care Team members are responsible for ensuring that all sharps are returned to the office promptly after each use.		<input type="checkbox"/>
Aerosols	Aerosols should not be purchased for the people we support in care unless it has been assessed by the CTL/Clinician that the person we support is able to use these in a safe and responsible way. If people we support have aerosols and they are not approved due to safety, these should be placed in the office and given out		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Environmental Setting Conditions			
Strategies	Description	Program Status/Comment	Active in Program
	by Care Team members when the person we support would like to use them and then returned and locked away after use.		
Door Chimes	Chimes should be fitted on the doors and when turned on make a noise to inform carers that someone has opened a door. Chimes should be on at all times and carers are to ensure that they are responding when they hear the chime. Care Team members are to ensure that they are checking the alarms are working at the start and finish of every shift.		<input type="checkbox"/>
Weapons	Weapons can be items such as knives, toys, sporting bats, guns, batons, sticks, rocks, rope, glass, or any other items that are deemed at risk of being used as a weapon. If people we support have access to any of these items or are using items they own in a dangerous way, the items are to be removed from the person we support and stored in the office. If the item is a personal item of the person we support, a plan must be put in place to manage safety in the future and the house expectations agreement is re-visited to assist the person we support to manage their belongings safely.		<input type="checkbox"/>
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>The house environment is set to respond to the highest level of risk.</li> <li>When a new person we support enters the program, the general environment will return to the base house set-up via a House Re-Set. This will reference the Set-Up images for the house as a guide.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Actively adding more access and ability for the people we support to interact and develop ability to tolerate and manage risk of normal household environments.</li> <li>The house environment is still set to reduce possible risks and maintain safety of the people we support living in the house.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>The house set up begins to mimic a 'normed' family home</li> </ul>		<input type="checkbox"/>

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Environmental Setting Conditions			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>As this phase involves target trauma recovery themes, it is important to maintain high vigilance around weapon type items and potential regression in ability to manage risk and safety.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>During this phase the focus is on assisting the person we support to prepare for the possible changes in house environment if transitioning to a new placement/independence.</li> </ul>		

Electronics and Wi-Fi Access			
Strategies	Description	Program Status/Comment	Active in Program
Electronics Access	<p>All people we support will have access to a TV and DVD player. As per usual parenting practice, access to the TV, DVD player and games will be restricted between the set educational hours on school days. This is because people we support will be supported to engage in school or educational activities between these times.</p> <p>People we support will not be permitted to have television and gaming equipment in their bedrooms and must utilise the shared space in the residence. However, people we support are able to use portable DVD players in their rooms during TV/Technology times as per their planner.</p>		<input type="checkbox"/>
Mobile Phones	<p>Each person we support is individually assessed on their capacity to safely manage a mobile phone. This assessment takes into consideration age, need, understanding of risk and ability to manage risk. As part of the assessment to obtain a mobile phone, the person we support must complete Cyber Safety psychoeducation.</p>		<input type="checkbox"/>
Hand-held gaming device/iPads/iPod/MP3	<p>These items are generally introduced in a planned and proactive way. Both program purchased and personally purchased items are managed under the same boundaries and expectations.</p>		<input type="checkbox"/>

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Electronics and Wi-Fi Access			
Strategies	Description	Program Status/Comment	Active in Program
	<p>The following general proactive strategies are put in place to manage these types of devices:</p> <ul style="list-style-type: none"> <li>The devices are used in alignment with the program activity planner.</li> <li>Both personal and program devices have the same expectations</li> <li>Time that the devices are available/used is linked with current research around healthy screen time.</li> </ul>		
Cables/Chargers	Access to device cables and chargers is linked to individual assessment of needs with each person we support and their ability to manage devices safely. This is linked with the Phased Trauma Recovery Model. Please refer to the below section relating to the phase specific aspects.		<input type="checkbox"/>
Gaming Console	<p>Generally, any personal gaming consoles are not allowed to enter any programs. This is due to concerns around issues with sharing personal items, risk of damage and ability to withdraw the time if unsafe. These items will be stored with the relevant Child Safety representative, for safe keeping. This may be an exception in SILP programs due to age and transition to independence.</p> <p>Most MC programs have the capacity to have a program gaming console that the people we support in the program can access. This aligns with social norms and allows increased learning around sharing, responsibility for taking care of shared items and group consequences if used incorrectly or in an unsafe way.</p>		<input type="checkbox"/>
Wi-Fi/Internet Use	<p>To be able to engage in any internet use, the person we support is required to complete Cyber Safety psychoeducation.</p> <p>Generally, program houses do not have Wi-Fi available. People we support may be able to access internet via a shared program computer or visit the local library at planned times. If assessed as needed, Wi-Fi can be installed, however this requires SPM approval.</p>		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Electronics and Wi-Fi Access			
Strategies	Description	Program Status/Comment	Active in Program
Program Computer	If assessed as safe, the people we support will have access to a program computer. This computer will have internet access (with full parent controls enabled), each person we support will have an individual log in, people we support will have clearly allocated time to access and use the computer and the computer will be located in an area where carers can supervise computer access. Before a person we support can gain access to the program computer, they must complete Cyber Safety psychoeducation.		<input type="checkbox"/>
DVD	Any DVD or game brought into the house by a person we support that is not age appropriate or contains violent or sexually explicit content will be confiscated and kept in the office or returned to where it was either purchased or borrowed. Multimedia rated R are not permitted on the premises of any residential.		<input type="checkbox"/>
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Chargers are kept in the office; devices are charged only in the office.</li> <li>During this phase people we support must complete the Cyber Safety psychoeducation.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>During this phase the aim is to increase capacity to safely and responsibly have the device chargers in the bedroom.</li> <li>Generally, devices are returned to the office during sleeping hours.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Focus on increasing capacity to manage the use and ‘time away’ from devices.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>Both chargers and devices are stored/managed in an age-appropriate way (e.g., adolescent in own bedroom, under 10 in the office)</li> </ul>		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Transportation			
Strategies	Description	Program Status/Comment	Active in Program
Transportation	<p>People we support are only permitted to be transported using the house/program vehicle. People we support are not to be transported in a carer's personal vehicle.</p> <p>People we support are not permitted to drive the program vehicle, even if they have their Learners, Provisional or Open Drivers Licence.</p> <p>Care Team members are not to answer any phone calls while driving including hands free. Care Team members are to check the mobile phone once they have reached their destination and return any phone calls that were received.</p> <p>The people we support must always travel with seat belts on and, if necessary, child safety locks on vehicles at all times. There are also strict safety procedures around the use and storage of car keys to ensure the safety of all people we support and Care Team members. Car keys, when not in use are to be locked in the office safe by the Care Team member immediately after each use. When transporting a person we support, Care Team members' personal belongings are to be locked in the boot of the car or in an identified safe location in the vehicle.</p> <p>People we support are not to be left unattended in the vehicle.</p>		<input type="checkbox"/>
Program Cars Seating Arrangements	<p><b>People we support under 7 years of age are required to sit in the back seat and use a booster seat or other suitable car restraint based on age.</b></p> <p>People we support over 7 years old generally sit in the back seat of the car, however, are able to sit in the front seat of the car where air bag ratings allow if needed. The Care Team should familiarise themselves with their program vehicle specifications as noted on the passenger side visor. People we support must be involved in discussions and safety planning/contracting about what safe behaviour is needed for them to be able to sit in the front seat of the car. The Care Team has discretion as to whether or not the people we support in the residential are able to sit in the front seat of the car.</p>		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Transportation			
Strategies	Description	Program Status/Comment	Active in Program
	<p>People we support can lose front seat privilege as a consequence of displaying unsafe behaviour in the car. This is reviewed on a fortnightly basis during the team meeting.</p> <p>Care Team members are required to complete the MC Car Seat Kidsafe training prior to installing any child restraint seats to ensure these are installed correctly and people we support are restrained according to the current legislation. Refer to <i>WHS SOP Transporting Clients</i> for further information. There are multiple trained MC team members who can complete this task. Consult with CTL/Clinician or SPM to arrange, if required.</p>		
Transport Risk Assessment	<ul style="list-style-type: none"> <li>Ensure that a risk assessment of the environment being visited has been undertaken.</li> <li>Ensure that the trip has been communicated to the person we support in plenty of time.</li> <li>Ensure that if an escalation takes place on the way to the venue, calm is first regained and then a decision made as to whether it is safe to continue.</li> <li>Ensure that distance from home / school etc., exposure to triggers and proximity and availability of assistance are considered.</li> <li>Ensure that Care Team members have mobile phone and quick access to key emergency contacts.</li> <li>Ensure that the communication protocols and expected actions in the event of an emergency are fully understood by the attending Care Team members and those who might be contacted.</li> <li>Ensure child locks are placed on appropriate back doors.</li> </ul> <p><b>Note:</b> <i>Transport will only occur if assessed as safe to do so.</i></p>		<input type="checkbox"/>
Travelling in Vehicles	<ul style="list-style-type: none"> <li>Vehicle is to be accessed once it is outside the garage.</li> <li>Ensure Care Team have keys, money, mobile phone, first aid kit (keep on person, not in the car), and other important items already packed in a</li> </ul>		<input type="checkbox"/>

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### Residential Care and Transition Services

Transportation			
Strategies	Description	Program Status/Comment	Active in Program
	<p>backpack on you, or in the vehicle, before you attempt to leave with the person we support.</p> <ul style="list-style-type: none"> <li>Vehicles must be turned off and keys carried securely by the driver when vehicles are being refuelled. For vehicles with a keyless start feature, keys must be stored in a faraday pouch to block the electromagnetic signal.</li> <li>If the person we support requires medication, ensure that the day's medication is packed in the event that there is a delay returning to placement on time.</li> <li>Carers to be clear on who is driving and who is sitting in the passenger seat prior to leaving the house; this should be communicated to the person we support before leaving.</li> <li>Care Team to have conversations prior to leaving the house regarding the expectations of safe behaviour and contracting with the person we support; this may involve reference to a Travel Safety Plan</li> <li>If the person we support has a Travel Safety Plan and is presenting as resistant to the Travel Safety Plan, an assessment of whether the outing should continue must be made.</li> <li>Use scripting of '100% safety' (rather than Zero Tolerance)</li> <li>Use scripting 'PAUSE' (rather than Pull Over) This is to be used when the person we support is beginning to display unsafe behaviour in the car during transport "We are going to PAUSE" – Care Team to pull the car over. A 'PAUSE' is not stopping the drive/getting to the activity. It is to reset the car travel safety plan with the person we support to continue the trip.</li> </ul>		
Reduce Boredom and Agitation During Travel	<ul style="list-style-type: none"> <li>Have iPad/novel/fidget toys available for use.</li> <li>Encourage the person we support to take sunglasses or a hat to reduce glare.</li> <li>Offer a comfort item such as a soft toy during travel.</li> <li>Prepare games that can be played whilst travelling, e.g., eye spy</li> </ul>		<input type="checkbox"/>

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Transportation			
Strategies	Description	Program Status/Comment	Active in Program
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Focus on helping the person we support to understand and engage in correct transportation safety.</li> <li>This phase involves an assessment period of the person we support's current understanding and behaviours that are present in the context of transport. This is unique for every person we support and the types of support that are provided must be specific to the person we support.</li> <li>There may be a need to support Care Team members to understand or re-think new and different types of risks with transport.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Focus on building capacity to manage risk and safety of transport.</li> <li>Introduction of public transport (if age appropriate), this may be carer supervised/supported for a period of time.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Transition to age-appropriate risk management of transportation, shift to personal responsibility and higher level of partnership.</li> <li>As this phase involves target trauma recovery themes, it is important to maintain high vigilance around transportation risk due to possible regression in ability to manage risk.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>During this phase the focus is on assisting the person we support to prepare for the possible changes in transport support if transitioning to a new placement.</li> </ul>		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Bag, Room, Property Searches			
Strategies	Description	Program Status/Comment	Active in Program
Room and Property Search	<p>If Care Team members suspect that the people we support have items that may cause risks to their safety or the safety of others, a room search may be conducted. Where possible, carers should inform the person we support of the room search and do the search whilst the person we support is present. If this is unable to occur and there are major concerns for safety, the room search can be conducted without informing a person we support and/or without them being present. When completing a room search, two carers should be present. If there is only one Care Team member on shift the room search can be conducted whilst the coordinator or on-call person is on the phone. This would be recorded in an incident report, including the reasoning and outcome of the search.</p> <p>The Care Team members are required to proactively engage in checking the property and house for unsafe items. It is possible for people we support to attempt to hide or store unsafe items on the property or in the house. Proactive cleaning and checking of the space support the reduction of future risks.</p>		<input type="checkbox"/>
Bag Search	<p>If a Care Team member suspects or has information to suggest that the person we support is in possession (on their person) of items that may cause risks to their safety or the safety of others, they can request that the person we support allow them to check their bag and comply with 'turning out' their pockets. It is vital that people we support are assisted to understand the House Expectations around illegal and dangerous items on entry into the program, to support their understanding in case of this request. Care Team members will not physically search a person we support and cannot force them to allow this search. In high-risk situations it is expected that the Care Team member would contact management to discuss plans moving forward if the person we support refuses the bag search. This would be recorded in an incident report, including the reasoning and outcome of the search.</p>		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Bag, Room, Property Searches			
Strategies	Description	Program Status/Comment	Active in Program
Illegal Substances/ Items	Possession or use of illicit drugs and alcohol is prohibited on the premises of any MC property. In addition, a resident, worker or visitor are prohibited from being under the influence of illicit drugs or alcohol on the premises. If illegal substances/items are identified this will be reported to managers and recorded in an incident report and reported to the police as required.		<input type="checkbox"/>
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Focus on safety, carers take the responsibility to maintain safety.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Focus on safety, the person we support to have increased responsibility to maintain safety.</li> <li>Type of items that are actively removed should reduce.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Focus on the person we support having age-appropriate responsibility to maintain their own safety and having access to normed items.</li> <li>Type of items that are actively removed should reduce.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>Focus on the person we support having age-appropriate responsibility to maintain their own safety and having access to normed items.</li> <li>Type of items that are actively removed should reduce</li> </ul>		<input type="checkbox"/>

House Meeting (Daily and Weekly)			
Strategies	Description	Program Status/Comment	Active in Program
Daily Planning Meeting	To help the people we support to develop planning skills, engage in proactive problem solving and increase positive house dynamic, they are supported to engage in a Daily Planning Meeting. During the morning routine the Care Team supporting the people we support will help them to engage in		<input type="checkbox"/>

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House Meeting (Daily and Weekly)			
Strategies	Description	Program Status/Comment	Active in Program
	<p>an informal check-in, review the planner and activities for the day and revisit house expectations.</p> <p>During the Daily Planning Meeting the Care Team may engage in 'like for like' type planning to ensure that the people we support are provided with a clear, structured plan for the day.</p>		
Weekly House Meeting	<p>As part of every program design, the people we support are supported to engage in a weekly house meeting during which a number of important matters are discussed, and decision are made. This meeting is designed to provide a time and place for people we support to raise challenges and concerns and have active involvement in decision making for the coming week. This meeting happens at the same time every week to support predictability and support capacity building in planning and collaboration. There is a general structure to the meeting and key questions asked of the people we support. Some of the key decisions made with the people we support are the next week's planned activities, the coming week's menu plan and negotiation on challenges encountered in the house. This meeting will also involve conversations around house safety (such as fire drills) and person we support's feedback. The Care Team supporting the people we support during the house meeting is actively engaged in the meeting and often other leadership team members will attend (such as the CTL/Clinician) when possible. Finally, this meeting is a forum to review house boundaries and expectations as a group. This is conducted, in particular, when a new person we support enters the program or there has been a critical incident relevant to house expectations and boundaries.</p>		<input type="checkbox"/>
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Key focus on process of the meeting, each person's role and the expectations of people engaging in the meeting.</li> <li>House boundaries are introduced and re-visited to support learning and orientation to the program.</li> </ul>		<input type="checkbox"/>

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House Meeting (Daily and Weekly)			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Active role of the Care Team member to role model the process of the meeting and decision-making negotiations.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Focus on helping people we support to build capacity to manage their engagement in the meeting. This may include being the meeting chairperson, taking meeting notes or preparing a snack to eat during the meeting.</li> <li>The person we support is assisted to teach new people we support the house expectations and learn about role modelling appropriate behaviour.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>The process needs to provide a high level of predictability and consistency as the person we support may rely on this to keep grounded and secure while engaging in challenging therapeutic interventions.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>Helping the person we support to develop or alter this process to best suit their new/next placement setting</li> </ul>		

House Agreements			
Strategies	Description	Program Status/Comment	Active in Program
House Agreements	To help the people we support to have a clear understanding of the program structure and support ongoing capacity to understand predicted carer responses, each house has a 'House Agreement' which clearly outlines an agreement between the people we support living in the house and the Care Team supporting them to understand the house bounds and expectations. This agreement is displayed in the house in a manner that ensures each person we support can understand the agreement and has been involved in agreeing to the expectations. People we support may be supported to		<input type="checkbox"/>

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House Agreements			
Strategies	Description	Program Status/Comment	Active in Program
	<p>develop their own visuals, or they may work on one shared version. Each House Agreement document generally covers three (3) main areas; however, it should be developed for the unique dynamic.</p> <ul style="list-style-type: none"> <li>• Management of communal and private spaces</li> <li>• Respect and respectful communication</li> <li>• Safety</li> </ul> <p>House Agreements must be developed with the support of the CTL/Clinician and may need to be reviewed/updated when a person we support enters or exits the program. The House Agreement is shared with Child Safety to support a joint approach from all stakeholders and reduce communication issues.</p>		

Person We Support/Sibling Physical Play Interactions			
Strategies	Description	Program Status/Comment	Active in Program
Play Fighting – Non-sibling Co-tenant	<p>In non-sibling cotenant programs, play fighting or ‘rough and tumble’ type games are not allowed. Carers should intervene in these situations immediately and assist the people we support to understand the expectation that people we support and carers respect each other’s personal space and bodies.</p> <p>It is acknowledged that it is important for people we support to engage in physical play and build physical awareness of their own bodies. These needs should be proactively met through activity planning.</p>		<input type="checkbox"/>
Play Fighting – Sibling Co-tenant	<p>In sibling cotenant programs, it is important to acknowledge that healthy sibling group dynamics include an aspect of physical play. However, people we support who have experienced trauma often experience challenges in regulating emotional and physical responses which can make physical play</p>		<input type="checkbox"/>

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Person We Support/Sibling Physical Play Interactions			
Strategies	Description	Program Status/Comment	Active in Program
	<p>unsafe. To support recovery in this area there are some proactive strategies that may be in place:</p> <ul style="list-style-type: none"> <li>No physical play can occur inside the program house. Inside time is classified as quiet time, with no physical 'play fighting'. Games that happen inside can include art, craft, board games, Lego/building etc.</li> <li>All physical play must occur outside, during structured times and planned games. These types of games can include, Tip, Hide and Seek, Stuck in the Mud, Red Light-Green Light, ball games, etc.</li> <li>When engaging in physical play there must be proactive reviewing of the game rules, expectations, and consequences if the rules aren't followed.</li> </ul>		
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Focus on learning and understanding house expectations and boundaries around physical play.</li> <li>Carers to hold responsibility of maintaining safety.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>People we support are supported to practice and enact the house expectations and boundaries.</li> <li>Increased expectation for people we support to maintain safety.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>People we support are supported to maintain the house expectations and boundaries.</li> <li>People we support are supported to teach others the house rules.</li> <li>Increased expectation for people we support to maintain safety.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>Focus on ongoing development and understanding of ability to manage safety.</li> <li>Focus on transferring the house expectations to new living environments.</li> </ul>		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Program Visitors			
Strategies	Description	Program Status/Comment	Active in Program
Program Visitors	<p>No person is to be invited into the program without the authorisation of a worker, with the exception of Departmental representatives (who must present identification). All visitors must be deemed suitable and approved by people we support and workers. Any visitors found to be unsuitable or unknown are not permitted in the residential.</p> <p>When approved visitors arrive, the worker must be informed of their arrival, purpose of visitation and ensure that they check that this is the person who is supposed to be seeing the person we support. Visitors are expected to sign the Visitor Book on entry. This is to ensure that all visitors are recorded correctly, and MC can track placement attendance.</p> <p>If a person phones the house to speak with a person we support, the staff member should get the name and number of this person and phone them back before giving the phone to the person we support. Staff to ensure that they are modelling appropriate stranger danger awareness.</p> <p>People we support are allowed to visit friends and sleepover at friends' houses. In order to determine if a sleepover is appropriate, CTL/Clinician will initiate phone contact with the parents, guardians or caregivers of the person we support's friend, complete an initial assessment of their suitability and outline the placement's expectations. Decision making will involve Departmental involvement. If the visit/sleepover is approved, further arrangements will be made including drop off and pick up times which must remain within a 48-hour timeframe. This would usually be planned in advance and be approved by the CTL/Clinician. Upon dropping a person we support at a sleepover, it is important that workers continue to assess the environment and meet the parents, guardians or carers in person before a final decision is made about the suitability of the arrangement. Note: workers cannot give approval for contact with family, and this must always be approved by a CSO and be in accordance with instructions from the CTL.</p>		<input type="checkbox"/>

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Program Visitors			
Strategies	Description	Program Status/Comment	Active in Program
	Note: SIL programs have unique strategies to manage program visitors. These are linked with the agreements made with people we support on entry into the program.		
Additional Program-specific notes			

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*Interaction Approaches*

Emotional Regulation Strategies			
Strategies	Description	Program Status/Comment	Active in Program
Emotional Regulation Strategies	<p>Each person we support is assisted to develop and practice a number of emotional regulation strategies. Due to the individualised nature of emotional regulation strategies, it is critical to review the therapeutic planning documents created for each person we support before supporting them. In addition to reviewing therapeutic planning documents, it is critical to engage the person we support in conversations to best understand what helps them manage their emotions and return to a 'calm' state after experiencing big emotions.</p> <p>People we support will have varying degrees of experience and strategies to manage their emotions, making it important to assess and assist each person we support individually. Some strategies that can be helpful when getting to know a person we support can be:</p> <ul style="list-style-type: none"> <li>• Develop or revisit their Go2Plan.</li> <li>• Mindfulness Activities               <ul style="list-style-type: none"> <li>○ 5-4-3-2-1 Method - 5 things you can see, 4 things you can hear, 3 things you can touch, 2 things you can smell, and 1 thing you can taste.</li> </ul> </li> <li>• Burning off extra energy through play</li> <li>• Managing the temperature (cooling the body down can help manage emotions)</li> <li>• Engage in sensory supports.</li> <li>• Weighted blankets</li> <li>• Chew on ice cubes.</li> </ul> <p>When helping the people we support with regulating their emotions it is key that the carers interaction style is based in PACE. Each person we support is on a different journey to learn about themselves and their emotions. It is</p>		<input type="checkbox"/>

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Emotional Regulation Strategies			
Strategies	Description	Program Status/Comment	Active in Program
	critical to remain calm, patient, and positive no matter how successful their attempts at regulating their emotions.		
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Focus on understanding current skills and understanding of emotions.</li> <li>Ensure safety when regulating emotions is challenging.</li> <li>Ensure relationship repair to completed and based in realistic and concrete justifications.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Focus on strengthening and broadening the person we support's strategies and resources to successfully regulate their emotions.</li> <li>Ensure safety as the person we support explores and attempts to build capacity.</li> <li>Provide clear and concrete feedback to the person we support on their developing skills and attempts to manage their emotions in a safety and healthy manner.</li> <li>Towards the end of this phase, provide opportunity for the person we support to manage their emotions with lessening support from the carers, providing real experiences of individual success and resilience.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Focus on helping the person we support to overcome larger and more challenging life tasks and activities with their more stable abilities of emotional regulation.</li> <li>Assist the person we support to engage in more self-management of their emotions, with a focus on deepening their internal understanding of their history, and identity.</li> <li>Move towards the person we support taking more responsibility for ensuring safety, with carer support.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p>		<input type="checkbox"/>

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Emotional Regulation Strategies			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Focus on supporting continued personal growth and age-appropriate skills.</li> <li>Support the person we support to transfer current emotional regulation skills to new living environments (family, foster care or independent living).</li> </ul>		

Carer Emotional Intelligence			
Strategies	Description	Program Status/Comment	Active in Program
TCI Four Questions	<p>TCI Four Questions</p> <ol style="list-style-type: none"> <li>How am I feeling? - Avoid engaging in the conflict cycle and implement your Go to Plan</li> <li>What does the person we support feel, need, and want? – Focus on what has happened for the person we support and what they are trying to communicate. Focus on addressing the need/feeling, not responding to the behaviour. Every behaviour is communication.</li> <li>How is the environment affecting the person we support? – Manage the environment to reduce environmental triggers or stimulation – this may include moving outside, turning down the TV, adjusting the temperature.</li> <li>How do I best respond? Respond based on your assessment of the person we support and what stage in the escalation cycle they are in.</li> </ol>		<input type="checkbox"/>

Known Triggers			
Strategies	Description	Program Status/Comment	Active in Program
Triggers	Every person has personal ‘triggers’ that have varying degrees of impact on our capacity to manage challenges. It is vital for those supporting the people		<input type="checkbox"/>

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## Proactive Strategies

### Residential Care and Transition Services

Known Triggers			
Strategies	Description	Program Status/Comment	Active in Program
	<p>we support to understand their own personal triggers, as well as be able to identify and manage the people we support's personal triggers.</p> <p>Understanding your own triggers refers to being personally aware of the contexts and situations that can make you feel uncomfortable or less in control. Understanding this information supports you to better manage these emotions, make better choices and increases your ability to assist the person we support. This is internal, personal work that everyone should engage in, conversations around this may be had in supervision if needed.</p> <p>People we support in out-of-home care generally have experienced if not one, many traumas in their short life. Due to these experiences, they are likely to have developed several personal triggers that increase a feeling of being unsafe, reduce their ability to manage their emotions, reduce their ability to think logically and make decisions, and possibly distort their perceptions of events in their lives. Due to this, knowing and reducing possible triggers for people we support is highly important. In some cases, referral information provides insight into known triggers which can support the Care Team in their understanding of the person we support, however this is not always the case. When interacting with the person we support, it is vital to pay attention to how they react to their environment, how they talk about their environment and the types of assumptions that they may make. These types of observations enable carers to identify possible triggers that are impacting the person we support and support therapeutic planning.</p> <p>Although every person we support is unique, there are some triggers that are common for people we support who have experienced trauma within the family home. They can include:</p> <ul style="list-style-type: none"> <li>• Times of the day (evening is common)</li> <li>• Planning and boundaries around food and mealtimes</li> <li>• Predictability of their daily routine</li> <li>• Setting boundaries (such as not being able to do something)</li> </ul>		

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Known Triggers			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Specific locations or contexts</li> </ul> <p>When a person we support is experiencing an emotional/trauma response due to a trigger they can present in many ways, however, will generally display a behaviour consistent with flight, fight, freeze. This is when knowing the person we support's triggers can support a reduction in this response and help the person we support to engage other responses. Proactive strategies may include:</p> <ul style="list-style-type: none"> <li>Removing the possible triggers until it is safe to help the person we support to learn to manage their emotional response.</li> <li>Provide scripting, and pre-warning information to reduce the shock or unexpected aspect of the trigger.</li> <li>Ensure predictability in daily planning and help the person we support to identify contingency plans if something changes.</li> <li>Don't 'rush' through challenging situations, help the person we support to take their time, stay 'in the moment' and identify the aspects that are keeping the person we support safe at that time.</li> </ul>		
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Focus on identifying triggers, completing assessment and exploration of the person we support's presentation.</li> <li>Focus on reducing known triggers, with the aim of helping the person we support to have minimal trauma responses while building trust and familiarity with the program and Care Team.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Focus on proactively helping the person we support to encounter known triggers that are 'unavoidable' or impact their daily functioning. This is highly carer supported and involves lengthy preparation and scripting.</li> <li>Assist the person we support to have appropriate control of their environment and ability to manage triggers.</li> </ul>		□

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Known Triggers			
Strategies	Description	Program Status/Comment	Active in Program
	<p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Engage in targeted therapeutic work to identify how the person we support sees the triggers, their place in the person we support's past and how the person we support would like their future to be.</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>Help the person we support to continue to develop a resilient response to personal triggers.</li> <li>Assist the person we support to transfer current skills to new environments</li> </ul>		

Community and Neighbourhood			
Strategies	Description	Program Status/Comment	Active in Program
Community and Neighbourhood	<p>Building and maintaining positive community and neighbourhood relationships is not only a key aim of MC, but also a critical learning opportunity for people we support to be supported in. Proactive strategies in this area are based around role modelling respectful and responsible community interactions. This is both viewed from a wider whole community aspect and a smaller, 'my street' aspect.</p> <p>Each MC program has a unique Neighbourhood Plan, which outlines the unique elements that are at play within the local community. It is critical to be familiar with these plans. When engaging with people we support in the community it is important to set a positive role model example for them to witness and understand. It is acknowledged that all MC carers are positive members of the community, however when caring for people we supporting with limited positive role models and or trauma experiences, they may require more overt role modelling and/or explanations as to why and how to best engage in the community.</p>		<input type="checkbox"/>

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Community and Neighbourhood			
Strategies	Description	Program Status/Comment	Active in Program
	<p>There are some key community and neighbourhood engagements that are important to follow in a proactive way:</p> <ul style="list-style-type: none"> <li>Ensuring the program house is neat and tidy, inside, and outside.</li> <li>Greet neighbours in a friendly, yet professional manner.</li> <li>If there is an issue or complaint from a community member or neighbour, respond in a calm, professional way.</li> <li>If there is approval for Emergency use of restrictive practices to be used in the community, ensure the carers have additional resources to reduce community concern, such as contact cards/" I'm a trained carer" cards.</li> </ul>		
Unconditional Positive Regard	<p>A key concept underpinning MC's support is the understanding that people we support in out-of-home care have often experienced several negative/traumatic events during their lives and often have developed very negative self-views. This negative self-view may have many negative impacts on development, wellbeing, and resilience.</p> <p>Unconditional positive regard translates to maintaining a positive view of the person we support, openly acknowledging that they have potential and with support can achieve their goals, and intentionally allowing the person we support ongoing opportunities to show personal growth.</p> <p>Unconditional positive regard does not mean letting people we support 'get away' with bad behaviour, or not addressing challenges or issues. Instead, it is about supporting the person we support during their challenges, in a positive, truthful, and encouraging manner.</p> <p>Proactively using unconditional positive regard, can include:</p> <ul style="list-style-type: none"> <li>Focusing on the learning opportunity, "It didn't work out this time, but next time we can try a different way".</li> <li>Acknowledging small positive changes and growth</li> <li>Understanding that change can take time, and everyone is on their own journey, "cleaning our lenses".</li> </ul>		<input type="checkbox"/>

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Community and Neighbourhood			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Every person needs someone to support and believe in them, be that person for the people we support.</li> </ul>		

Carer Boundaries and Connection			
Strategies	Description	Program Status/Comment	Active in Program
Carer Boundaries and Connection	<p>Managing interpersonal boundaries and connections can be a challenging area for the people we support in out-of-home care. This can be due to multiple factors, however, is often linked with the challenge of not having positive primary attachments and examples of safe adults. To engage in proactive strategies around managing carer boundaries and connection, the following aspects must be followed:</p> <ul style="list-style-type: none"> <li>Conversations within the program should be focused on the people we support in the program and relevant events relating to the people we support within the program.</li> <li>Carers should not engage in conversation about personal topics, including personal family matters, other carers/staff's family or personal life.</li> <li>Carers should not discuss MC information, i.e., new people we support, missing people we support, changes to other programs, other people we support in the care of MC, MC organisational matters, changes in leadership, or direction of the organisation.</li> <li>unless there is a plan and direction to do so by the leadership team.</li> <li>Carers are not to bring any items into the program or gift items for the children.</li> <li>Do not bring anything from home. (e.g., toys, games, furniture, rugs)</li> <li>Birthday presents for children must be a combined gift from all staff, no individual gifts to be given. Management needs to approve any gifts. MC provides gifts for birthdays, Christmas etc.</li> </ul>		<input type="checkbox"/>

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Carer Boundaries and Connection			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Carers are not permitted to have their personal phones in the residential area nor provide/show them to children. Carers should store their phones in the office area. They may be checked when appropriate in the office. All ring tones should be shifted to silent. If carers are required in an emergency family members can contact the administration or on-call team.</li> <li>Carers are to leave the office to engage with the people we support within the house environment – all communication with people we support will occur in the main living areas of the house and not at the office door.</li> </ul>		

Promoting Independence			
Strategies	Description	Program Status/Comment	Active in Program
Promoting Independence	<p>Promoting independence can be task-focused or it can be focused on an attitude or way of thinking. Helping people we support to seek help when needed and appropriately rely on carers to help them is a key element of repairing and developing secure, therefore promoting independence, is not about not helping or making people we support do everything themselves. Promoting independence is about people we support learning to feel confident to learn new skills, trying to solve problems when they can and seeking appropriate help when they need it.</p> <p>Carers are encouraged to engage in several strategies to guide people we support to learn and develop personal independence. When engaging people we support in learning new skills, it is key for carers to engage in a dynamic risk assessment to ensure that it is safe to engage in skill building and that the environment is appropriate to respond to challenges the person we support may encounter. These may include questions such as:</p>		<input type="checkbox"/>

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Promoting Independence			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Is there enough time to allow the person we support to try again if needed?</li> <li>Is it safe for the person we support to engage in capacity building right now?</li> <li>What level of skill does the person we support have and what level of skill are we aiming for?</li> <li>Is this a current therapeutic goal/is this a focus right now?</li> </ul> <p><i>Personal Appearance</i></p> <p>It is important that each person we support is supported to always present themselves in a neat and age-appropriate manner. Carers should proactively guide the people we support to ensure their presentation matches the context of each outing or situation. Carers should be conscious that when visitors are expected the people we support are prepared and appropriately dressed.</p>		
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Focused on understanding current skill level.</li> <li>Focused on building relationship of trust and confidence in carers providing support.</li> </ul> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Focused on building new abilities (in line with age and developmental ability)</li> <li>Focused on independence within a clear structure, such as opportunities for choice that are appropriate, while the adults ensure safety and predictability.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Focused on increasing independence level (in line with age and developmental level)</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p>		<input type="checkbox"/>

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Promoting Independence			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Focused on growing independence or transferring current skills to new environments</li> </ul>		

Transitioning Between Activities			
Strategies	Description	Program Status/Comment	Active in Program
Transitioning Between Activities	<p>People we support who have experienced trauma or disrupted caregiving often display behavioural challenges during times of transition. These can be around stopping an activity or starting a new task, leaving a location or returning. This is often linked with worries or concerns about not understanding the plan, what to expect next or how people will respond to them. Uncertainty is common challenge for many people, not just people with trauma history. The following points outline proactive strategies to use to help people we support during transitions:</p> <ul style="list-style-type: none"> <li>Start the day with the Daily Planning meeting. This meeting aids the person we support to understand the whole plan for the day. During this meeting, carers are to support the people we support to understand all the different activities/events of the day and discuss any needed changes.</li> <li>Some people we support find it hard to remember their day, it is important that each person we support has a copy of their daily planner to re-check what they have on that day. The daily planner should be clearly presented and easy to understand.</li> <li>Carers are to remain 'on planner', so that the person we support is able to predict their day. This predictability of following the planner, helps build trusting and consistent relationships.</li> <li>Carers are to assist the person we support by giving them prompts before the activity/event ends or starts, this could be a 15, 10, 5 minutes reminder or visual reminders of the next activity.</li> </ul>		<input type="checkbox"/>

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Transitioning Between Activities			
Strategies	Description	Program Status/Comment	Active in Program
	<ul style="list-style-type: none"> <li>Carers to use scripting around “we have just finished ..., we are going to do .... now, and later we will be doing ...”</li> </ul>		
Phase Specific Aspects	<p><i>Phase 1 – Foundation</i></p> <ul style="list-style-type: none"> <li>Structured and formalised plans</li> <li>Structured and formalised start and end times</li> </ul> <p>* Proactive planning to have favoured activities after harder activities</p> <p><i>Phase 2 – Capacity Building</i></p> <ul style="list-style-type: none"> <li>Focus on maintaining predictable support around activity transitions.</li> <li>Focus on person we support to increase their ability to successfully manage transitions.</li> </ul> <p><i>Phase 3 – Targeted Therapeutic Intervention</i></p> <ul style="list-style-type: none"> <li>Focus on reduced support during transitions and increasing person we support’s ability to manage emotions (anxiety) and seek reassurance of plans</li> </ul> <p><i>Phase 4 – Continued Growth/Transition</i></p> <ul style="list-style-type: none"> <li>Support ongoing growth or transfer skills to new environments</li> </ul>		<input type="checkbox"/>

Handovers (in house and external)			
Strategies	Description	Program Status/Comment	Active in Program
Handovers (in house and external)	<p>There will be only 1 staff member in the office at any given time, unless staff are completing handover with an oncoming/outgoing worker. There should never be more than two staff in the office for handover at any given time. Staff to ensure that they have the office door locked at all times, particular vigilance should be given to the office space if this is a targeted area by the people we support.</p>		<input type="checkbox"/>

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# Practice Paper

## Proactive Strategies

### Residential Care and Transition Services

Handovers (in house and external)			
Strategies	Description	Program Status/Comment	Active in Program
	<p>Car keys, shift keys and filing cabinet keys are to be returned upon completion of each shift and secured in their designated areas (e.g., safe and lock boxes).</p> <p>Handovers will occur at the change of shift i.e. 9am and 2:30pm daily. Handovers are to consist of two workers (unless other arrangements have been made) and signing off on the House shift report. All questions on the report must be addressed and then signed by the workers. Handovers are allocated 30 minutes and need to be concise and informative to allow sufficient time for the staff member commencing shift to review documents such as emails, care planning or notes.</p> <p>Workers can choose to complete handover in the office or conduct an active handover in the common area of the house; however, it will be the care worker's responsibility to ensure that there is appropriate and adequate supervision of the people we support whilst handovers occur. Workers will take great care to respect confidentiality and to be sensitive to where each person we support is at and what they are comfortable sharing. Information not shared in the active handover will need to be shared confidentially in the office space and the Handover Checklist completed and signed.</p>		

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