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

- The welfare and best interests of the people we support are paramount.
- People we support in care should be supported in their placement, so they are safe and protected from further harm. It is in the context of this nurturing environment that emotional and psychological healing will occur and the skills required for a successful transition to independent living learned.
- The transition from care experience should be seen and experienced as a positive 'rite of passage', a celebration of the person we support's emerging adulthood.

## Scope

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

## Procedure

### 1. Transition/exit pathways

- 1.1 People we support may exit an MC RCaTS program through one of the following pathways:
  - Planned transition to another placement;
  - Planned transition out of care (e.g., family reunification or to independence); or
  - Unplanned exit.
- 1.2 Regardless of the way a person we support exits, MC workers will ensure that all interactions with people we support are therapeutically sound, in accordance with the *FS PP RCaTS RES Phased Trauma Recovery Model for Out of Home Care*.
- 1.3 Placement exits and transitions are undertaken in partnership with the Department of Child Safety, Seniors, and Disability Services (the Department) and other stakeholders.
- 1.4 In preparation for a transition or exit, the Care Team Leader (CTL)/Transition Services Team Manager (TM) will negotiate with the Department regarding informing the person we support of the placement movement.
- 1.5 All planning and preparation for transitions will be documented in their care planning documents, stakeholder meeting minutes and discussed as part of Formulation and/or Care Team Meetings.
- 1.6 When a person we support is transitioning from a program:
  - 1.6.1 CTL will ensure they leave with suitable basic, clean clothing, shoes and luggage (no plastic or striped bags);
  - 1.6.2 The CTL will complete the *FS FORM RCaTS Getting to Know Me* with the young person to support their transition to a new care provider, where applicable.
  - 1.6.3 The residential program will hold a farewell event and may give them a parting gift (ideally that commemorates their time with the service);
  - 1.6.4 The CTL will ensure the person we support has all of their personal belongings, including anything stored by MC during the placement period by

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reviewing their Assets and Possessions Register on the CTARS Client Profile;

- 1.6.5 The CTL will assist the child or young person to complete the *CTARS Exit Questionnaire – Under 12 Years/12 Years and Over* and input the responses into the corresponding CTARS form.
- 1.6.6 The CTL will advise the Business Support Team of the placement closure via an email within one (1) business day so that the CTARS Client Profile can be deactivated, or hierarchy changed.
- 1.6.7 The CTL will prepare the child or young person's CTARS file for closure.

## 2. Planned transition to another placement

- 2.1 When a person we support transitions to their new placement the CTL will provide appropriate support and intervention planning documents, *CTARS Exit Questionnaire – Under 12 Years/12 Years and Over*, *FS FORM RCaTS Transfer of Medication to New Placement*, and Child Health Passport to their Child Safety Officer (CSO) and, if appropriate, the carer or coordinator of the new placement.
- 2.2 CTL, and if required Senior Program Manager (SPM), will participate in discussions with the new provider and other stakeholders as required to ensure appropriate sharing of information to support a full understanding of the person we support's needs.
- 2.3 Where personal belongings are left behind, the Senior Residential Care Worker (SRCW), in consultation with the CTL, will ensure that these belongings are appropriately stored and transported to the Department or, if appropriate, the new placement.
- 2.4 The person we support may maintain contact with the Residential Care Workers (RCWs) to support their continuity of care. CTLs must discuss this with the CSO to ensure that this is in the person we support's best interests and to support Departmental decision making about approved contacts.

## 3. Planned transition out of care or to independence

- 3.1 People we support may transition out of care as part of a planned reunification plan or may transition to independence upon turning 18 straight from a residential care placement. These exits are planned and comprise the Departmental Case Plan for the person we support.
- 3.2 When a person we support transitions to independence, all transition activities as outlined above will occur. In addition:
  - 3.2.1 The CTL will where applicable, assist the person we support to apply for a return of any rental training savings they have made by completing the *FS FORM RCaTS RES Refund of Monies Paid in to Rent Training Program* at least one (1) month before the planned closure.
  - 3.2.2 The CTL will provide appropriate support and intervention planning documents, *CTARS Exit Questionnaire – Under 12 Years/12 Years and Over*, and Child Health Passport to the person we support's CSO.

## 4. Unplanned exit

- 4.1 In some instances, a person we support may exit the program in an unplanned way. Some instances of this include:

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- When a person we support's behaviours or actions become unsafe within the residential care setting;
  - When a person we support is remanded in custody;
  - When a person we support has 'self-placed' or has chosen to live somewhere other than the placement that the Department has provided, and the Department has chosen to close the MC placement;
  - When the Department decides to end a placement without notice; or
  - When a person we support's Child Protection Order is revoked or expires.
- 4.2 Upon receiving advice that the person we support will be exiting the placement, the CTL/TM will liaise with the Department and workers around how the exit will proceed.
- 4.3 The CTL/TM may provide an email or telephone update on the person we support to the new carer/parent and CSO. The CTL/TM will also ensure that any significant details, including health or medical information, are passed on to whoever needs to know. Provision of medication is to be recorded on the *FS FORM RCaTS Transfer of Medication to New Placement*.
- 4.4 The CTL/TM will provide appropriate support and intervention planning documents, to their CSO (or relevant, appropriate persons) within five (5) business days of the exit.
- 4.5 If appropriate, workers may organise a farewell event or a farewell gift for the person we support after they have exited.
- 4.6 The CTL/TM will prepare the person we support's CTARS file for closure.

## 5. Records management

- 5.1 All documentation, including MC forms and any correspondence, relating to a person we support's exit or transition is uploaded to the person we support's Client Profile within CTARS.
- 5.2 After a person we support has exited, the CTL/TM must review their file and ensure that all relevant documents have been completed, in preparation for the closure of the file and deactivation of the profile.
- 5.3 The CTL/TM will inform the Business Support Team of the person we support's exit and file closure. CTL/TM will deactivate the CTARS Client Profile.
- 5.4 Upon exit, MC has a responsibility to return the person we support's file to the Department. The Business Support Team will coordinate this process.
- 5.5 Archiving of client files occurs in line with the *FS PROC RCaTS Records Management*.

## Definitions

### Care Team Leader (CTL)

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

### CTARS

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

### Senior Residential Care Worker (SRCW)

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## Definitions

Employee tasked with the day-to-day support and coaching of staff and running of an MC Residential Care Program site.

### **Transition Services Team Manager (TM)**

Employees tasked with client care planning and care management oversight of Transition Services.

### **Worker**

Employee tasked with providing daily care for people we support.

## References

Child Protection Act 1999 (Qld)

Department's Child Safety Practice Manual (CSPM)

FS DOC RCaTS Program Overview

## Related Documents

CTARS Exit Questionnaire – Under 12 Years

CTARS Exit Questionnaire – 12 Years and Over

FS FORM RCaTS Getting to Know Me

FS FORM RCaTS Transfer of Medication to New Placement

FS PROC RCaTS Records Management

FS FORM RCaTS RES Refund of Monies Paid in to Rent Training Program

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

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