Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR321	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

1.0 Purpose

Lifestyle Centred Services Pty Ltd's aim is to work with participants, families, advocates, communities and other providers to achieve the best outcome for the participant. The purpose of this collaboration is to allow all parties to share ideas and knowledge to ensure that the supports are relevant, appropriate and in line with the service agreement.

2.0 Scope

Lifestyle Centred Services Pty Ltd is committed to ensuring that the Staff understands the beneficial aspects of a collaborative approach for the participant.

3.0 Policy

This collaborative approach requires Staff to work with relevant parties when:

- Locating key workers with a family and other provider
- Working with other providers in the supply of supports or services
- Assisting the participant in transitioning and exiting the service
- Building the participant's capacity
- Planning with supports for the participant
- Developing service agreements.

Staff must cooperate with other agencies in the delivery of service. This collaboration may include initial contact, sharing ideas and input from the participant, their families and advocates, following through on ideas of a provider, and actively listening to discussions.

We will collaborate with all relevant parties to provide participants with the opportunity to access a service network that meets the full range of their needs. The Program Coordinator will establish

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR321	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

communication with the relevant service provider, so our organisation can maintain collaborative relationships and protocols, and participate in networks with relevant agencies.

Information, knowledge and skills are communicated and shared between the participant, family, advocate, provider, and other collaborating providers. Lifestyle Centred Services Pty Ltd will work with the participant, their family and advocate to ensure that the participant maintains functionality.

4.0 Procedure

4.1 Key worker

Participants and families may require assistance to locate the right person to work with the participant. To do this, our team will undertake the following process:

1. Discuss the participant's requirements with participant, family and advocate.
2. Gain formal written consent to share and gather information with other provider.
3. Contact other service providers working with the participant to collaborate and determine the criteria.
4. Identify at least one (1) key support worker to contact participant, family and advocate, and the other providers.
5. Inform the participant, family, advocate of the identified person for their approval.
6. Record the process undertaken and results in the participant’s service agreement.

4.2 Collaborating with other providers

The Program Coordinator will make initial contact with other providers, after obtaining consent from the participant, their family and advocate. Various methods will be used to maintain contact, e.g. email, phone and networking. All records of contact are kept in the Participant Service Agreement.

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR321	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

4.3 Transition and exit

The participant's needs, interests or aspirations may change during the delivery of their supports. These changes may lead to a need to transition to, or exit from, their current service. If this occurs, with the consent of the participant, we will contact the relevant service provider to:

- Collaborate with providers and the participant to develop a plan of action
- Request or send documents relevant to the participant
- Confirm current supports, practices and needs to enable the participant to transfer or exit smoothly
- Identify risks and develop a risk management plan
- Develop a transition/exit process for the participant and confirm details with the participant
- Work with the participant during the process
- Review the effectiveness of the transition upon completion
- Document the process in the participant care plan.

Risks associated with each transition to/from Lifestyle Centred Services Pty Ltd are identified, documented and outlined in our 'Transition or Exit Policy and Procedure' and 'Risk Management Policy and Procedure'.

4.4 Capacity building

The participant's capacity building process is designed to improve and retain their skills and knowledge, so that they can maintain and improve their functionality.

To build and support the participant's functional capacity Lifestyle Centred Services Pty Ltd will collaborate with:

- A participant, their family and advocate to affirm, challenge and support

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR321	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

- Other providers to further develop the participant's skills and to improve practice and relationships.

4.5 Participant outcomes

Collaboration with a participant, their family and advocate is the basis of ensuring functional outcomes are focusing on the participant's needs, priorities and skills. Details of collaborations are to be recorded in the service agreement.

4.6 Support planning

During the assessment and care planning process, collaboration is undertaken with a participant, their family or advocate to:

- Complete a risk assessment
- Document a risk assessment
- Plan appropriate strategies to manage/treat known risks
- Implement appropriate strategies to manage/treat known risks
- Conduct an annual review, or earlier, according to the participant's changing needs/ circumstances.

4.7 Service agreements

Lifestyle Centred Services Pty Ltd will collaborate with the participant to develop a service agreement which establishes the:

- Expectations of both parties

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR321	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

- Supports to be delivered
- Conditions associated with the delivery of supports, including details of why particular conditions are attached.

With the consent or direction from the participant Lifestyle Centred Services Pty Ltd collaborates in the development of the care plan with other providers to:

- Develop links
- Maintain links
- Share information
- Meet the needs of a participant.

5.0 Related documents

- Participant Information Consent Form
- Participant Care Plan
- Privacy and Confidentiality Agreement
- Risk Management Policy and Procedure
- Service Agreement
- Transition or Exit Policy and Procedure

6.0 References

- NDIS Practice Standards and Quality Indicators 2018
- Privacy Act (1988)

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR322	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

1.0 Purpose

The purpose of this policy is to outline the legislative requirements and practice procedures for undertaking support services for NDIS participants. Our organisation will comply with the requirements of NDIS Practice Standards and Quality Indicators.

Compliance with this policy is a condition of appointment for all persons engaged in providing services on behalf of Lifestyle Centred Services Pty Ltd.

2.0 Scope

To instruct our team how to plan the development of a care plan to incorporate the participant's wants, needs and aspirations. Plans are to include the type of Staff and time and length of the service linked to the registration group on an NDIS Plan.

3.0 Policy

All participants and their support networks are aided to collaborate and participate in the development of a goal-oriented care plan. The care plan will reflect an individual’s goals and aspirations and will review the strengths and functionality of the participant. The plan is based on the presumption of capacity and will safeguard the risks and needs of the participant.

The care plan is to incorporate both the participant’s supports (described as nature of a coordination, strategic or referral service or activity) and reasonable and necessary supports funded under NDIS (activities that support goals to maximise independence, allow to live independently and undertake mainstream activities).

The care plan will provide transparent written information to the participant outlining the services and type of support/s they will receive from Lifestyle Centred Services Pty Ltd. Where there is a change in the participant’s needs, preferences or goals, the amended care plan will communicate the change in supports required by the participant.

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR322	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

Staff must be screened, trained and qualified in the roles that they undertake.

3.1 Support planning principles

- The care planning process is consultative where the participant, family, friends, carer or advocate work together to identify strengths, needs and life goals, with a focus on choice and decision-making.
- The participant's preferences, values and lifestyle choices should be supported (wherever possible).
- Care plans should promote the valued role of people with disabilities that is of their choosing.
- Lifestyle Centred Services Pty Ltd promotes functional and social independence and quality of life.
- Care plans will contain goals.
- Agreed service choices should reflect the participant's personal goals.
- Care plans should be creative, flexible and not restricted to set patterns or methods of service delivery.
- Activities and supports in the plan must be inclusive of the participant's chosen communities and maintain connections with their community to allow for active participation.
- If a participant identifies as Aboriginal or Torres Strait Islander, then their community will be contacted to allow for engagement and provision of support services.
- The care plan is reviewed regularly (at least annually) and amended to respond to the participant's needs and preferences.
- The care plan should be strength-based, seeking to maximise independence and build on the participant's existing networks.

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR322	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

- The care plan should be provided to the participant in their first language, where appropriate or requested.
- The participant or their advocate may request a review of the care plan at any time.
- Staff conducting the care plan development will have the necessary skills and competence to undertake this function.
- A participant with a disability will be facilitated to assist comprehension of their NDIS Plan, including:
    - Understanding and self-directing their NDIS Plan
    - Understanding the supports in their NDIS Plan
    - Understanding funded support budgets
    - Purchasing general funded supports
    - Purchasing stated funded supports
    - Managing and paying for their supports
    - Choosing their providers
    - Making agreements with their preferred providers.

4.0 Procedure

4.1 Care plan development

4.1.1 Planning

- Explain the care plan development process to the participant.
- Arrange a meeting time with the participant and, if applicable, their advocate or family.

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR322	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

- Develop the care plan with as much input, choice and decision-making from the participant as they want. Document the reasons for the decisions made (should a participant choose to have minimal input into their care plan).
- Before meeting with the participant, review the:
    - Participant intake form
    - Participant assessment information
    - Referral documents
    - Other relevant notes or data available that will assist in understanding the participant as an individual.
    -

4.1.2 Providing information to the participant

- Emphasise to the participant why it's important they identify their personal goals and aspirations.
- Use the appropriate care plan as a prompt to assist the participant in identifying areas where Lifestyle Centred Services Pty Ltd services may help them realise their goals.
- Outline the prompts on the plan, including discussion of the participant's physical, emotional, spiritual, cultural, community, social and financial needs.
- Provide the participant with a clear understanding of their choices and service options available, so they're able to make informed decisions about their choices and priorities.
- Explain to the participant any information-sharing requirements with other parties.
- Provide the participant with examples and suggestions of how Lifestyle Centred Services Pty Ltd services may be able to help them achieve their goals.

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR322	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

4.1.3 Facilitating the development of participant-centred goals

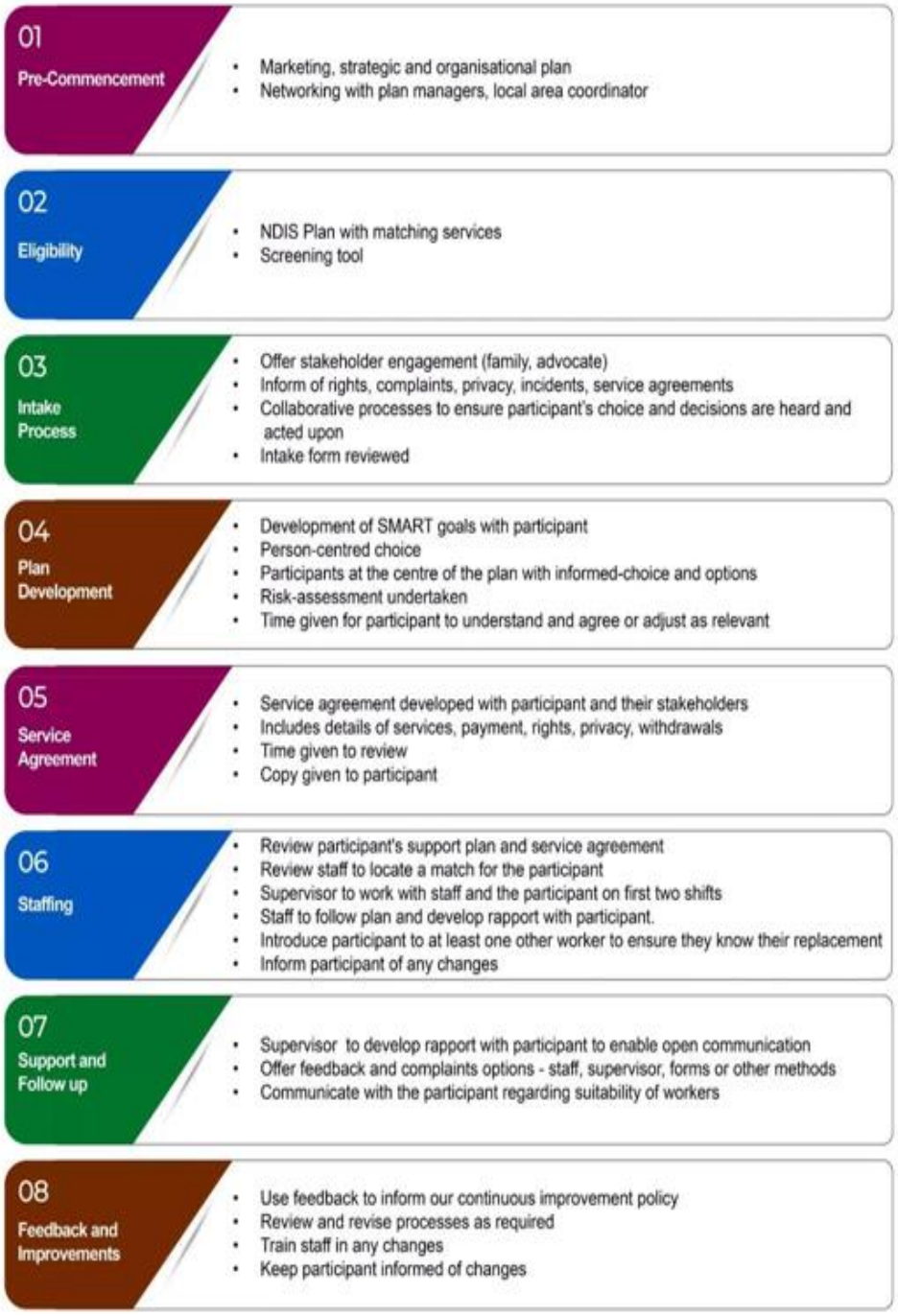
- Work with the participant and their advocate/s to identify their personal goals.
- Ask the participant to identify the types of help or assistance that would be most important to them.
- Help the participant recognise their strengths and capabilities.
- Transform the participant's goals into SMART (Specific, Measurable, Attainable, Realistic and Timely) goals, e.g.
- Simple goal: To be able to collect the mail.
- SMART goal: To walk to the letterbox, without assistance, every day to collect the mail.
- Set a time frame for each goal, so progress can be measured. e.g. walk to the letterbox, without assistance, to collect the mail and to achieve this by November 30.
- Use the participant's expressed goals, priorities, goals and agreed actions to develop their care plan.

Consideration will also be given to:

- Financial resource capacities and any limitations of Lifestyle Centred Services Pty Ltd services or specific programs to be utilised
- Capacities, expertise and appropriateness of current Lifestyle Centred Services Pty Ltd Staff to provide the services
- Availability of specialised subcontracted Staff or services, if applicable
- Other services or individuals who will provide services, as designated by the participant
- Volunteer supports available

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR322	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

- Determining, with the participant, how each goal will be measured so progress can be recorded
- Identifying, with the participant, any potential barriers to achieving their goals and then developing strategies to alleviate those barriers
- Working with the participant to prioritise their goals, if many goals are identified. For each goal list the actions, responsibilities, frequency and duration of services to be coordinated or supplied on behalf of the participant. Document all the



Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR322	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

information in the care plan.

- Identify all stakeholders, i.e. Participant, family, advocate/s, community engagement links and other services or agencies that will undertake to assist the participant in achieving each goal. Document this in the care plan.

4.2 Care plan delivery and review

- Negotiate specific days for services/supports and document in the Participant Care Plan.
- Where possible, agree upon time ranges for the services to build a level of flexibility into the service roster, e.g. start time between 1:00 and 1:30 pm and provision of one (1) hour of domestic assistance.
- If not yet finalised, negotiate service fees and record these in the participant's service agreement and on the care plan.
- Ask the participant to sign the care plan to acknowledge their agreement with it.
- Agree on the criteria to evaluate the effectiveness of Lifestyle Centred Services Pty Ltd service responses and document this in the care plan.
- Ensure that all involved stakeholders have copies of the agreed care plan.
- Explain to the participant that the Program Coordinator will monitor the progress of the care plan, and that the participant may also request a review of the plan at any time.

5.0 Related documents

- Lifestyle Centred Services Pty Ltd assessments
- Participant Intake Form
- Service Agreement
- Care Plan

Document Identifier	Version	Reviewed By		Authorised By	
LCS-PP-COR322	0	Ruth Wearne, QM		Tarina Venturin, OM	
Next Review:	4/4/2021	Date:	4/4/2020	Date:	4/4/2020
NDIS Standard	Core Module 3.2 Support Planning				

6.0 References

- NDIS My First Plan and Developing the Plan 2016
- NDIS Practice Standards and Quality Indicators 2018
- Privacy Act (1988)
- Work Health and Safety Act 2011